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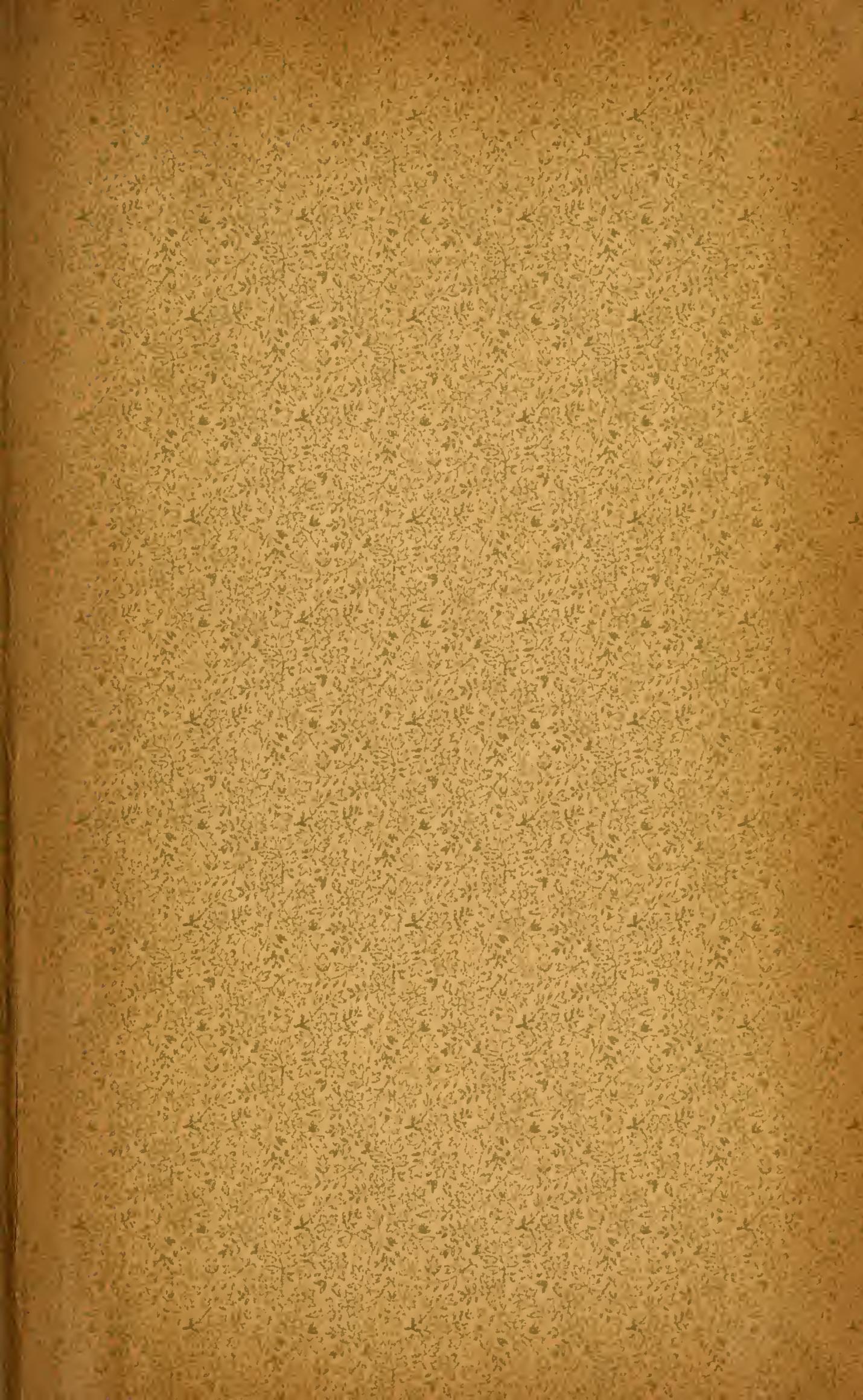
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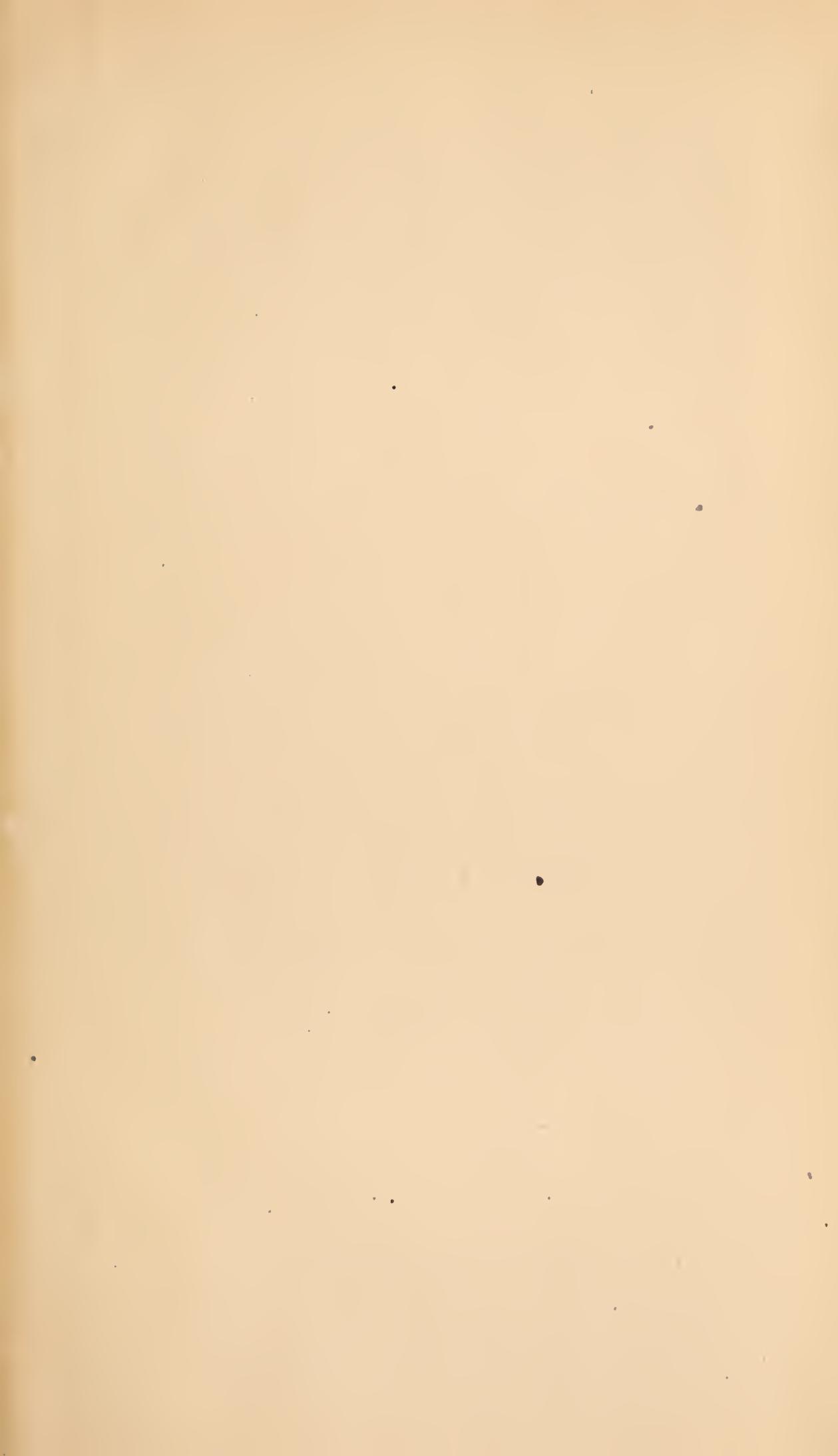
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"Brevity, indeed, upon some occasions, is a real excellence."

—CICERO, BRUT. 13.50.

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## ARCHIVES OF DERMATOLOGY.

OCTOBER, 1874.

### Original Communications.

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#### RÖTHELN.

(*EPIDEMIC ROSEOLA—GERMAN MEASLES—HYBRID MEASLES, ETC.*)

BY J. LEWIS SMITH, M. D.,

*Physician to Charity Hospital, Physician to Infant's Hospital, etc., New York.*

RÖTHELN is an epidemic eruptive disease, of rare occurrence heretofore, and little known in this country. I am not aware that it is described in any American medical journal or treatise. Meagre and imperfect descriptions of it have appeared in some of the British journals, and cases have been quite fully described by certain British physicians. On the continent, especially in Germany, rötheln has, it is said, occurred now and then as a mild epidemic, limited to small areas for a considerable number of years, although the German writers have published only brief descriptions of it, and they have hardly yet recognized it as a distinct disease, or any thing more than a form of morbilli.

An epidemic of this rare and interesting malady has recently prevailed in New York city, the first, so far as I am aware, on this continent. In a general practice of more than twenty years, extending over a considerable portion of this city, I had previously observed nothing like it, and other older physicians having a large general practice, have informed me that they consider it

an entirely new disease with us. Those who think that they have occasionally seen isolated cases of it previously to the recent epidemic, evidently refer to roseola.

This epidemic of rötheln commenced in New York near the close of 1873, and attained its maximum prevalence in March and April, 1874, when it declined, occasional cases occurring throughout May. The first case which I observed occurred in the middle of December, in Seventy-first street, being in the suburbs of New York, on the north. A few weeks later, cases were so numerous in the thickly settled portions of the city as to attract the attention of many physicians. It was evident that a disease had appeared with which we were not familiar, and as the eruption occurred in points, or small circumscribed patches, it was, I think, usually designated by the physician, in want of a more accurate name, epidemic roseola, or was spoken of as a spurious measles. Those physicians who were familiar with foreign medical literature saw the resemblance between these cases and those of rötheln as described by British and continental observers, but in certain at least of the foreign cases the duration of the rash was said to be seven days (*Liveing, Lancet*, March 14, 1874, and *Medical News and Library*, May, 1874), whereas in the cases in New York it commonly disappeared by the fourth day. But this discrepancy was not sufficient to invalidate the belief in the identity of the New York disease with the foreign rötheln. It was readily explained by the difference in the seasons in which the cases occurred, for Liveing observed his cases in June and July, and the greater the external heat the longer the duration of the eruption, as we will see.

Between the middle of December and the first of May I had observed and treated this malady in eighteen families. Cases occurred in three other families living in the same houses with some of those which I attended, and as they were fully and clearly described to me, so that there could be no doubt as to their nature, I have included them in my statistics. Forty-eight cases were observed in the twenty-one families. During May, when the

epidemic was declining, I saw six additional cases occurring singly in families, making a total of fifty-four.

AGE.	CASES.
From 8 months to 1 year .....	2
“ 1 year to 2 years .....	4
“ 2 years to 5 “ .....	16
“ 5 “ 10 “ .....	23
“ 10 “ 15 “ .....	3
“ 15 “ 30 “ .....	6
<b>TOTAL.....</b>	<b>54</b>

The age of the youngest patient was eight months, and that of the oldest thirty years. Seventy-two per cent of the cases were between the ages of two and ten years, so that rötheln is pre-eminently a disease of childhood. Individuals in and beyond the middle period of life seem to have nearly an immunity from it. The age of the oldest patient of whom I have been informed, was about forty years. On March 25, when I was on duty in the New York Catholic Foundling Asylum, rötheln occurred in a boy aged four years, following closely an extensive epidemic of measles among the inmates. In April, during the attendance of Drs. O'Dwyer and Reid, about thirty children were affected with it in this institution, while among the large number of female nurses and employes, who were chiefly between the ages of twenty and thirty years, all but three escaped.

**Premonitory Stage.**—Premonitory symptoms are in most instances either absent, or so mild as to attract little attention. It not unfrequently happened in the New York epidemic, that the parents were first made aware of the sickness of their children by observing the eruption. In one or two instances in my practice, children were sent from school not because they felt too ill to remain, but on account of the unusual appearance of the skin. Commonly however, in those old enough to express their sensations, a premonitory stage of some hours, or a day, or even of longer duration was present, consisting of slight languor with

headache, and sometimes nausea. Now and then patients vomited, previously to the eruption, as they frequently did during the first and second days of the eruptive stage. In only one instance did I observe grave prodromic symptoms. A boy, aged eight years, was suddenly seized with clonic convulsions, and while he was in the hot bath for the relief of these, the rash appeared along his back.

**Symptoms**—*Tegumentary System*—(a)—*Skin*.—The eruption may appear first upon the back as in the above case. In other instances it is first observed upon the chest or neck, and in others still upon the cheek or forehead. As in morbilli it travels downward, appearing after some hours or a day upon the legs. It occurs upon all parts of the body unless upon the scalp and the palmar and plantar surfaces of hands and feet. The eruption in a majority of the cases which I have observed, gradually faded and disappeared, as already stated, by the fourth day. Children who were kept warm in bed, or in warm apartments, had it longer than others. In many instances traces of it were still visible when the patients were heated by exercise or excitement several days after recovery. A girl aged thirteen years, presented traces of it at times, though indistinctly, for three weeks. In most of the cases in the New York epidemic the rash commonly occurred in small circular patches, having nearly the size as well as color of those in morbilli, interspersed with which were numerous smaller eruptions, scarcely more than points of the same color. Between these patches and points the skin presented the normal appearance, unless an occasional goose-flesh contraction. In exceptional instances the rash resembled that of scarlet fever, extending continuously over a considerable extent of surface. Thus in a boy of three years it presented so closely the appearance of the scarlatinous efflorescence over the trunk, that were it not that the temperature was constantly below one hundred degrees, and within three or four days all febrile movement had ceased, I would probably have considered the malady a mild scarlatina. In certain patients the eruption, being in circum-

scribed patches and points, in the beginning like that of measles, becomes in two or three days confluent, so as to resemble the scarlatinous efflorescence, while over other parts the patches remain discrete. This was the character of the eruption upon the third and fourth days upon the extremities of a little boy in the Foundling Asylum. The rash is attended by considerable itching, disappears on pressure, produces slight roughness of the surface as ascertained by passing the fingers gently over it, and it usually disappears without desquamation. Exceptionally there is a slight branny exfoliation, and in one instance which I observed the exfoliation was as considerable over the abdomen as in cases of scarlatina.

(b.) *Mucous Membrane.*—In connection with the cutaneous eruption, a mild inflammation also occurs of the mucous membrane covering the fauces, buccal cavity and nostrils, and of the reflection of this membrane over the eyes and eyelids, namely, of the conjunctiva. In certain patients this inflammation is scarcely appreciable, but in the majority it arrests attention at once. It produces more or less soreness of the throat, swelling of the tonsils, and even of the lymphatic glands in the vicinity of the tonsils, sneezing, and some times a slight discharge from the nostrils. It produces also a suffused, reddish, or weak appearance of the eyes, with a moderately increased lachrymation. On inverting the eyelids the palpebral conjunctiva is seen to be injected. In certain patients a moderate puriform secretion collects at the inner angle of the eyelids. The eyelids are probably in most cases more or less œdematous, but the swelling is usually slight, and is apt to be overlooked by the physician. In three cases, which I now recall, mothers have directed my attention to this œdema. In one of these, to wit, an infant of twenty-three months, there was so great tumefaction of the eyelids, commencing about the time when the eruption began to fade, that light was totally excluded from the eyes, and it was impossible to ascertain their condition. The skin covering the eyelids retained nearly its normal appearance, and the puriform secretion alluded to above, appeared between the

lids. In three or four days the œdema of the lids, and the hyperemia of the conjunctiva rapidly declined.

*Pulse—Temperature.*—The largest number of accurate daily observations relating to the temperature made during the epidemic in this city, were, I think, those of Dr. Reid in the Catholic Foundling Asylum during March. He has kindly furnished me his statistics relating to this symptom, as follows: “The number of closely observed cases in which the temperature was taken was twenty-four. In seventeen of the cases the temperature ranged from  $97^{\circ}$  to  $99^{\circ}$ ; in six it reached  $100^{\circ}$ ,  $100\frac{1}{4}^{\circ}$  and  $100\frac{3}{4}^{\circ}$ ; in one it reached  $103\frac{1}{4}^{\circ}$  on the second day of the eruption, but remained so elevated only one day.” In certain patients Dr. Reid observed what he designates “a tendency to the development of an ephemeral fever.” These observations correspond closely with those made by myself in private practice. Thus in sixteen cases I found the temperatures taken each day constantly between  $98^{\circ}$  and  $100^{\circ}$ , with a pulse under 110 per minute, except in one case in which it numbered 124. In certain other cases there was a more decided febrile movement, lasting from one to two or three days, occurring usually in the commencement. Thus a girl aged three and a-half years had a temperature of  $101\frac{3}{4}^{\circ}$  and a pulse of 128. In another case the pulse was 124 and temperature  $102^{\circ}$ . In another, a girl aged three and a-half years there was active febrile movement on Saturday night, occurring without apparent cause. This abated on the following day, and she seemed well till Tuesday, when the febrile movement returned, and the eruption appeared. On Thursday the temperature from  $102^{\circ}$  to  $103^{\circ}$  fell to  $99\frac{1}{2}$ , and within a day or two she was convalescent. In two other patients from two to four days after the disappearance of the eruption, an accession of fever occurred, lasting about one day, and attended by complaint of pain or distress in the epigastric region, but without vomiting or diarrhoea. In one of these the temperature was  $103\frac{1}{4}$  and the pulse was 130 per minute; in the other case temperature and pulse did not seem to be below these figures, but they were not

accurately ascertained. Occasionally in the New York epidemic the febrile movement was obviously due more to complications than to the primary disease. Thus in two cases which I observed the febrile movement was mainly attributable to mild diphtheritic inflammation which had attacked the fauces.

The observations therefore of Dr. Reid in the Foundling Asylum and my own in private practice, show that the febrile movement is constantly mild in most cases of uncomplicated rötheln, but that certain patients have temporary exacerbations of fever in which the temperature is as elevated as in scarlet fever or severe measles.

*Respiratory System.* — The mucous membrane of the larynx, trachea, and bronchial tubes does not participate or participates but slightly in the inflammation, which involves the nasal, buccal and faucial surfaces. A large proportion of my patients had no cough whatever, but others had an occasional slight cough. A few had a cough commencing so long previously that it was evidently accidental and not a symptom.

*Digestive System.* — The tongue in rötheln is moist and of normal appearance, or covered with a slight fur. The appetite is impaired but not lost, there is a little or no thirst and the bowels are regular. Nausea is a common symptom both during the premonitory stage and in the period of the eruption. Vomiting was present in several cases which I observed as one of the first premonitory symptoms; in certain patients it occurred likewise on the first or second day of the eruption. In other patients there was no nausea so far as could be ascertained, either immediately before, or during the disease. This symptom is less common in rötheln than in scarlet fever, but is as common apparently as in morbilli. Foreign observers have occasionally remarked the presence of albumen in the urine of patients affected with rötheln. I am not aware that it was observed in the New York epidemic, but I think that the urine was seldom examined by the appropriate tests. I made the examination in three different cases but found no albumen unless a slight trace in one.

**Complications—Prognosis.**—The only complications which occurred in my cases were those already alluded to, namely, mild diphtheria in two patients. Diphtheria being at the time prevalent, the diphtheritic inflammation occurred by preference upon those faecal surfaces which were already the seat of inflammation. We see the same preference in cases of scarlet fever and measles. In the Foundling Asylum varicella complicated one case and pneumonia another. In a third case pneumonia appeared three days after the disappearance of the eruption. The prognosis in rötheln is very favorable. Patients do not die from the severity or depressing effect of the disease as we observe in cases of scarlet fever, and with the exception of diphtheria there does not seem to be in it any tendency to the development of complications.

**Nature.**—Is rötheln a malady *per se*, or is it a malady with which we have been familiar under another name, but whose form and character are modified by unusual meteorological conditions. Most of the cases in the New York epidemic bore considerable resemblance to cases of morbilli, both as regards the appearance and duration of the eruption, and the mucous inflammations. Parents often diagnosticated measles before the arrival of the physician, and the physician himself at first glance sometimes made the same diagnosis. But in rötheln the shortness and mildness of the premonitory stage, lack of uniformity and certain peculiarities of the eruption already pointed out, absence of bronchitis and general mildness of symptoms, with uniform favorable prognosis, afford a strong contrast with measles. But the decisive proof that rötheln is not a modified measles is found in the fact that the one does not prevent the occurrence of the other. Of the forty-eight cases observed by myself prior to May 1, nineteen at least had had measles, and one who had the rötheln took measles a month subsequently. I have already stated that in the Foundling Asylum rötheln closely followed an epidemic of measles. A considerable number of the children affected with the former disease had recently recovered from the latter.

That rötheln is not a form of scarlet fever is evident from the fact, that as regards at least the New York epidemic, the rash was in most instances quite different from the scarlatinous efflorescence occurring, as we have seen, in small more or less circular points and patches. Moreover, there is in rötheln a slight febrile movement and general mildness of symptoms quite unlike what we observe in scarlatina; or if there is a considerable febrile movement it has a short duration. But the decisive proof of an essential difference between these two diseases, is found in the fact already stated in regard to measles, namely, that an attack of the one malady does not prevent the occurrence of the other. There are it is true cases in which it is difficult to make the differential diagnosis between rötheln and mild measles or mild scarlatina at first, but when the course of the malady has been closely observed for three or four days it rarely happens that we are unable to make out its character.

The first cases of rötheln observed in the New York epidemic were often, as I have stated, designated by the name epidemic roseola by the physicians who were called to treat them, since they were ignorant of their true nature, and in want of a better name. But rötheln differs so widely from the peculiar form of dermatitis known as roseola, that it may be properly said to have no kinship with it. The successive occurrence of the eruption in rötheln over the upper and then the lower part of the body, but covering the whole surface, its definite duration of three to five days, its size usually larger than that of roseola, are points of difference. Moreover, roseola would not, without so great a change in its character as to become virtually a distinct disease, occur in the cool months, without any appreciable dietetic cause, as an epidemic over a certain area, and for a limited time, affecting whole households of children and sparing other households as well as individuals of a certain age. We therefore conclude that rötheln though presenting certain resemblances to roseola, as well as to measles and scarlet fever, is a disease *per se*.

The following is a brief history of the forty-eight cases already

alluded to as occurring in twenty-one families previously to May 1, or during the time in which the epidemic influence was most pronounced. The initials represent the surnames.

E——, Seventy-first street, between Ninth and Tenth avenues. John, aged seven years, attending a public school, had rötheln, commencing about December 18, 1873. One week later it appeared upon his brother aged four years. The only remaining child, a girl of ten years, was affected with it on the week following, namely, between January first and third. A niece of Mr. E., aged four years, visiting in his family during the time in which the first child was sick, but returning home to another street soon after, had the same eruption about December 27. Alice R., aged ten years, a frequent visitor at Mr. E.'s and living in the same street, also had rötheln about January 4.

W——, 500 West Forty-fourth street. A boy aged eight years, attending the Forty-fourth street public school, had rötheln, commencing with clonic convulsions on February 22. A brother aged fifteen years escaped. I was informed that a girl aged three years, living in an adjoining room on the same floor, had the eruption three weeks previously. She had previously had measles. An infant aged one year, in the same room escaped. On the floor below, a school girl aged ten years, had the same disease in January, introducing it into the house. Subsequently, her sisters and brother, aged eight, six and four years, took it. All the children of the family had had measles. Mr. W. informed me that the two children of a relative living a few blocks distant, who have been intimate with his own children, have also had an eruptive disease which was diagnosticated roseola by the physician. Their ages were eight and six years, and there was an interval of three weeks between the two cases.

K——, 441 West Forty-fifth street. A boy aged eight years had rötheln on February 12. A girl aged seven years on February 19, a girl aged five years on February 28, and a boy aged three years on March 7. An infant aged nine months had also an indistinct rash, but nothing marked. The oldest two children attended a public school.

I——, 413 Eighth avenue. A girl aged nine years, attending public school, had the eruption over whole body on March 4. A boy aged eight years, on March 26, a boy aged seven years on March 28, and another boy aged five and a-half years, on March

31. The only remaining child of this family, namely, a girl aged fifteen months, had the eruption April 10.

S—, 440 West Thirty-sixth street. A boy aged eight years, attending public school, had rötheln March 6, and three weeks subsequently his brother aged six years, was affected with the same. Four other children escaped.

K—, also 440 West Thirty-sixth street. A girl aged ten years, attending the same school with the boy in the S. family, had rötheln at the same time as the boy. Caroline, aged eight years, and a boy aged six years, had it ten days subsequently.

G—, 20 East Forty-ninth street. Mrs. G—, aged twenty-five years, had the eruption of rötheln on March 21. Mrs. G. has two children, an infant aged nineteen months, who took the disease on the day following its appearance upon the mother, and a boy of four years who took it three days subsequently.

S—, 834 Eighth avenue. A girl aged twelve years, attending a public school, had the eruption over the entire surface on March 6, and an infant aged eight months on March 24. Mr. S. has one other child who escaped. The features, especially the eyelids of the girl, were somewhat swollen.

F—, 148 West Forty-fifth street. Rötheln occurred in a boy aged five and a-half years, who attended a private school, on March 18. On April 5th it appeared upon the brother aged three years, and upon a servant girl aged twenty-one years. Two children escaped.

N—, 233 West Fifty-fourth street. An only child, a girl aged nine years, attending the same private school with the preceding child, had the same eruption with the usual symptoms on March 23.

S—, 652 Sixth avenue. A girl aged thirteen years, attending a public school, was the first patient. About three weeks subsequently the disease appeared nearly simultaneously upon her two sisters, aged twenty-three and ten years. A boy aged fifteen years, and a girl aged six or eight years escaped.

S—, 248 West Thirty-seventh street. The first case was a girl aged nine years, attending school, who took the disease March 20. Thirteen days subsequently a second child, aged eight years, had the eruption.

L—, 227 West Forty-eighth street. A girl aged twelve years, attending one of the public schools, had the eruption April 14. It

is not known whether the only remaining child took the malady or escaped.

C—, 706 Ninth avenue. Rötheln appeared in the infant aged twenty-three months, on March 12. Three other children escaped.

H—, 38 West Fifty-first street. Rötheln occurred in a girl aged four years, in the last of February. About two weeks subsequently, the true time not being exactly ascertained, another child, aged two and a-half years, was affected. Two other children escaped.

S—, 403 West Forty-sixth street, aged eight years, attending a private school, had the eruption March 6. The other children, namely, two girls, escaped.

M—, 48 West Fifty-first street. A girl aged six or eight years, was affected on March 2. The remaining children (five) escaped. The rooms in this house were large and well ventilated.

B—, 655 Washington street. McC—, 826 Seventh avenue. L—, 455 West Fiftieth street. There was only one child in each of these families, except in Mr. L.'s, in which there was a young infant who was kept separate. After May 1, when the epidemic was rapidly declining, I observed, as already stated, six cases occurring singly in families, with perhaps one exception, and so far as known, without any history of exposure. The exceptional case was a young servant girl, having charge of children, who, it was said, had had the measles a few days previously, though their malady may have been rötheln.

The cases of an epidemic disease which occur when its causes or conditions are most strongly operative, and which are at this time apt to be typical, obviously afford the best data for studying its nature. Such are in the present instance the forty-eight cases detailed above. In thirteen of the twenty-one families, the first cases were children, who, up to the time of the seizure, were attending the public or private schools, and in certain instances those who were nearly simultaneously attacked living perhaps in streets wide apart, were attending the same school. We see in this a close resemblance to the mode in which those common exanthematic diseases of childhood, which are universally admitted to be contagious, as scarlet fever and measles spread in a

community. It is largely through the schools that these diseases are introduced into families.

In most of the families containing two or more children, the cases were multiple, not occurring simultaneously but in succession, as if the malady were contracted from the one first affected. This is what we daily witness in the spread of the exanthematic fevers. In the first of the above families, to wit, Mr. E—s, a girl attending one of the public schools takes rötheln in the middle of December. The two remaining children sicken with it, one week and two weeks later. A niece visiting in the family at the time when the first child was sick, but returning home to another street soon after, also has the eruption on December 27. Alice R. aged ten years, a frequent visitor at Mr. E—s, living in the same street and several times exposed to his children during their sickness, takes rötheln about January 4. West Seventy-first street where this family resided, is suburban and thinly settled, and I could not learn of other cases in that locality.

These facts and cases seem to me to demonstrate the contagiousness of rötheln, at least during the time in which the conditions are most favorable for its development, or during the time in which the epidemic influence is most pronounced. During the declining period of the New York epidemic, the cases which I observed, as they occurred singly and without known exposure, lent no support to the theory of contagiousness.

From facts and observations like the above, we infer that rötheln is one of the exanthematic fevers. It resembles varicella in general mildness of symptoms, in the absence of dangerous complications or sequelae, and in the uniformly favorable prognosis, while its symptoms and history show its close alliance with measles and scarlet fever. If this view is correct we must believe that it possesses an incubative period, which in the cases detailed above apparently varied between seven and twenty-one days. The incubative period therefore resembles that of scarlet fever, which as is well known is very unequal in different instances.

Rötheln, like varicella, requires little treatment. I commonly gave small doses of quinine to my patients.

NOTES ON URETHRAL STRICTURE, WITH A DESCRIPTION OF A SET OF INSTRUMENTS FOR THE INTERNAL DIVISION OF STRICTURES OF MEDIUM AND LARGE CALIBRE.

BY F. J. BUMSTEAD, M. D.

**I**N the invention of all or nearly all instruments designed for internal urethrotomy, every effort has been made to have the diameter of the shaft as small as possible, in order to effect its introduction through tight and narrow contractions. "The less the diameter of the shaft, to the larger number of cases can the instrument be applied," has been the reasoning of the inventor, who naturally desires that *his* instrument should have a field of application as wide as possible, or that, indeed, it may monopolize the whole field of internal urethrotomy.

This idea had some foundation at a time when the belief prevailed that only narrow strictures should be subjected to internal division; but it has less weight at present when probably more strictures of moderate or large size are incised than narrow ones. Moreover it may well be doubted whether any one instrument can be adapted to all the varying cases met with in practice, and there seems to be no reason why the surgeon should be limited to only one urethrotome any more than to one knife, in the performance of his operations.

In a number of instances while performing internal urethrotomy, I have found the supposed advantage of a small shaft to be a decided disadvantage, since the point readily became engaged in any existing false passage or lacuna; time was thus lost in attempts to introduce it, especially embarrassing if the patient was to be kept under ether; and yet a properly curved metallic sound of fifteen or more millimetres in circumference could be passed through the canal with the greatest ease. It is not necessary to give such cases in detail; they have been mostly cases of old strictures, several of them operated upon before, which had been

maltreated in incompetent hands with the effect of producing false routes.

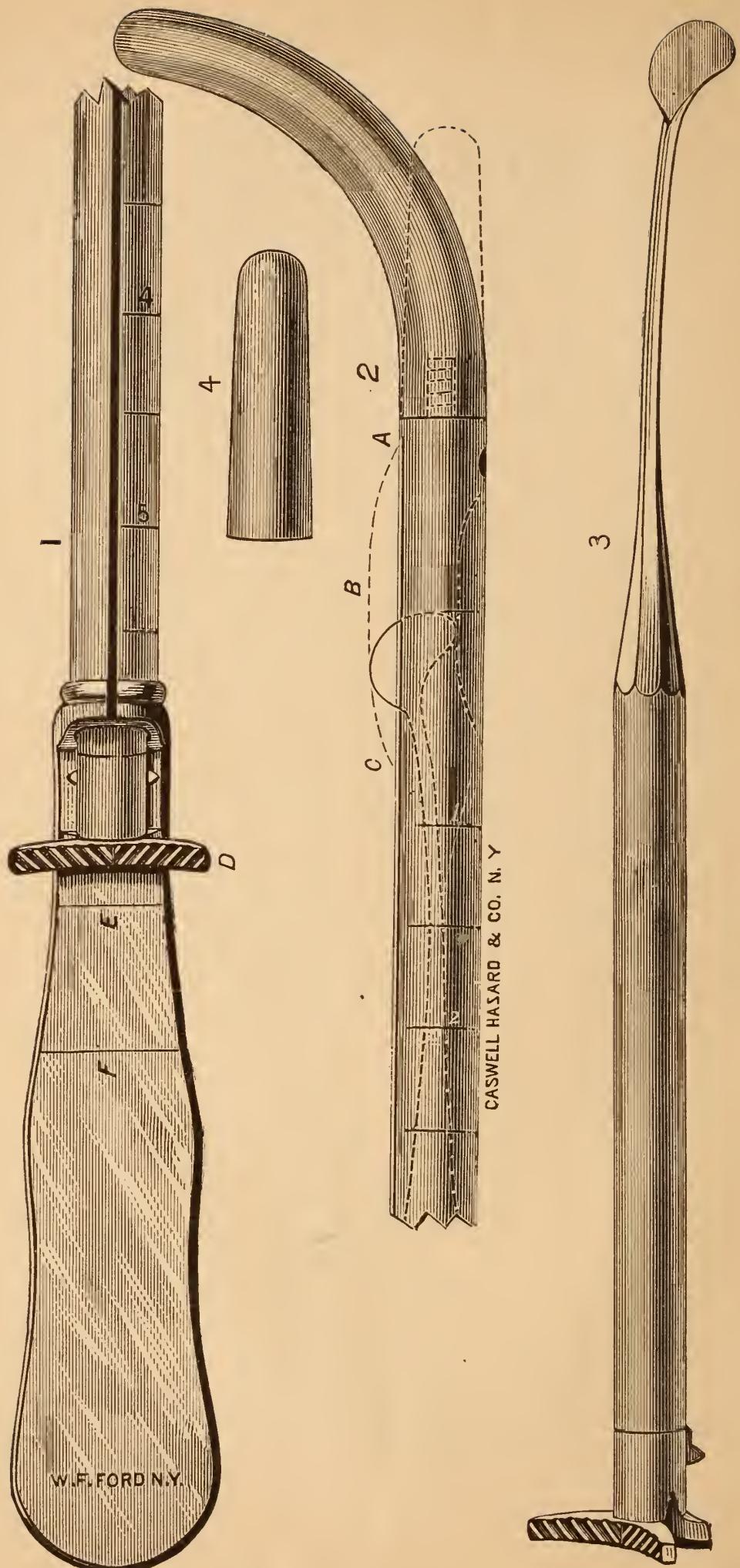
After meeting with a case of this kind last November, the simple idea occurred to me that any urethral sound of sufficient thickness to bear a groove and a cutting blade traveling in the same, would fill all the conditions of an urethrotome; that all, or any desirable number, of a set of sounds might be thus prepared, and that thus the surgeon could employ an instrument of such a curve as he was in the habit of using, and of such a size as he could most readily introduce; also that by adapting the size of the shaft to the calibre of the stricture, the latter would be put upon the stretch and its division be facilitated.

This idea was carried out with the valuable assistance of the surgical instrument maker, Mr. William Ford, and a set of four (this number being judged sufficient, but susceptible of indefinite increase) instruments prepared, which, in repeated trials, have accomplished the object intended.

The relative sizes of the instruments are such that each will cut up to the size of the shaft of the one next larger to it, and the four sizes are as follows:

- No. 1. Size of shaft 15 Fr. scale, cuts up to No. 20.
- No. 2. Size of shaft 20 Fr. scale, cuts up to No. 25.
- No. 3. Size of shaft 25 Fr. scale, cuts up to No. 30.
- No. 4. Size of shaft 30 Fr. scale, cuts up to No. 38.

The accompanying wood-cut represents the largest of these instruments in its full dimensions: 1 and 2, the shaft or sound with its blade inserted in the groove and partially withdrawn; 3, the blade entirely removed; 4, a straight tip which may be screwed on, after unscrewing the curved one, so as to adapt the instrument to the straight or curved portion of the canal. Both tips are conical, the points tapering to several sizes smaller than the shaft. The blade plays over a bridge, about an inch and an eighth long, in the floor of the groove as shown in Fig. 2, A B C. The instrument is introduced with the blade pushed home and concealed at the point A, and the cutting of the stricture effected



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by withdrawing the blade to the point C, where it is again concealed in the shaft.

The shaft is marked off into inches and half inches, commencing with the point B, where the blade is projected to its fullest extent; the cross-line E upon the handle also indicates when the blade is projecting, and F when it is again concealed. The whole of the instrument, with the exception of the cutting portion, is nickel-plated; the shaft after being used is readily cleaned by passing a stream of water through the groove; the blade is to be kept, when not in use, withdrawn from the shaft, and by these means all danger of rust is avoided.

It will be seen that the principle of these instruments is not a new one; it is merely an old method extended and made applicable to a larger number of cases. It is the same as the one made use of in the urethrotome of my friend, Dr. George A. Peters, and commonly called after his name, although Dr. Peters was fore stalled by several years in his invention by Ricord, who gives a plate and a description of the same instrument, under the name of *coarctotome*, in his Notes to Hunter on Venereal.\*

As already stated, the smallest of this set of instruments is 15 millimeters in circumference, corresponding, of course, to No. 15 of the French scale. For tight strictures, below this measure, which are to be submitted to internal urethrotomy, Ricord's original *coarctotome* may be employed, but I have found it preferable to use Maisonneuve's urethrotome, which will, from its smaller diameter, pass any stricture permeable to a metallic instrument, and the blade of which cuts fully up to No. 15 or even beyond. A tight stricture, therefore, having been incised to this extent, its further division may be executed to any desired degree by the successive introduction of the instruments here described, the normal calibre of the canal being taken as the guide.

32 WEST 26TH STREET, NEW YORK.

\* I have to acknowledge a very stupid oversight on my own part. After translating and publishing Ricord's Notes to Hunter, I described this instrument under the name of "Peters," in the first edition of my own work on Venereal.

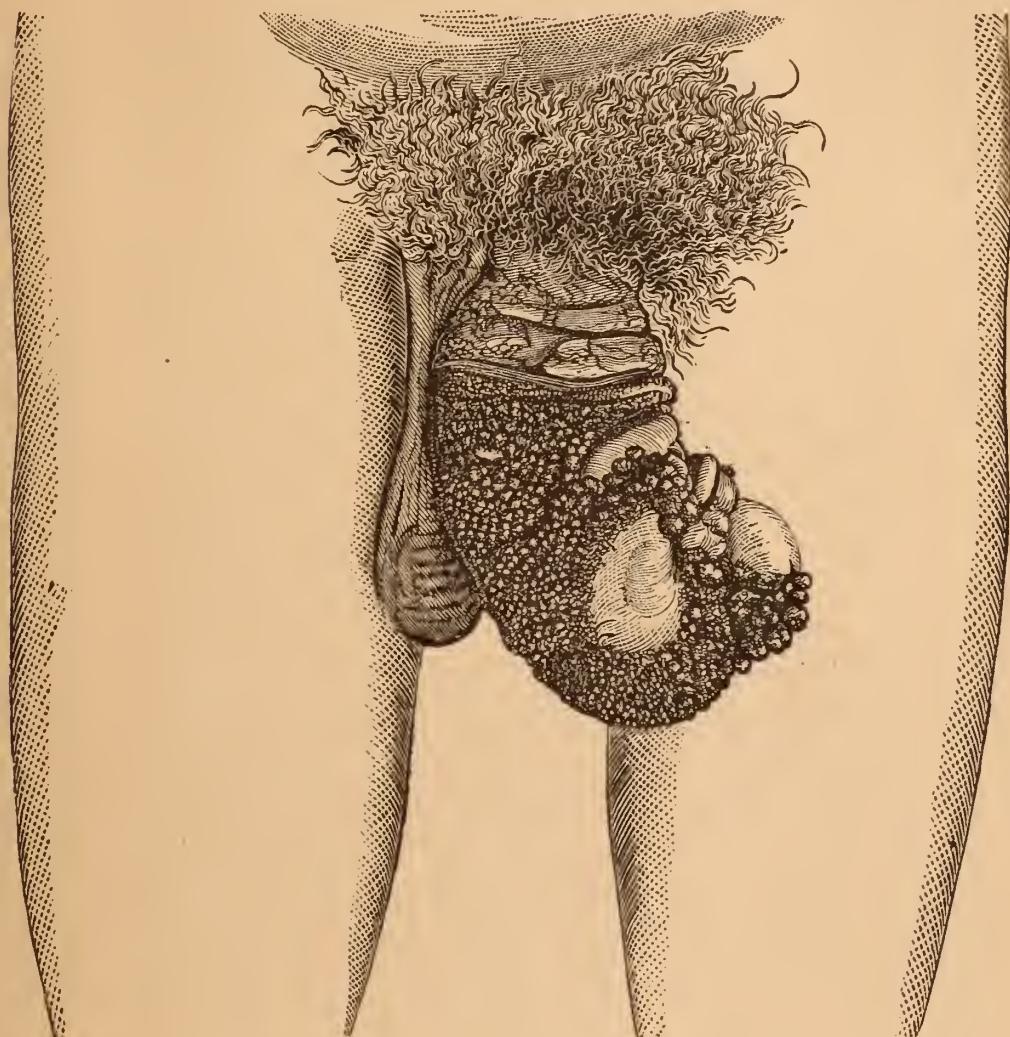
ELEPHANTIASIS OF THE PENIS FROM STRICTURE  
OF THE URETHRA; AMPUTATION.

BY ROBERT F. WEIR, M. D.,

*Attending Surgeon to the Roosevelt and St. Luke's Hospitals, etc.*

THE following unique case entered the Roosevelt Hospital during my term of service in June, 1873. It occurred in a man of enfeebled condition of body, aged fifty-nine years, and by occupation a watchman, and who had never lived in a hot climate. The penis measured nearly seven inches in length and ten inches at its greatest circumference. Its shape and peculiarities are best understood by reference to the accompanying wood-cut. There it will be seen, that the disease involved nearly the whole of the antescrotal portion of the penis, and that its greatest intensity was most manifested along the under surface of the penis in the region of the retracted prepuce. Along the base of the glans and especially at the frænum the hypertrophy was, by comparison, markedly distinct; the latter being converted into an irregular bunch of grape-like masses, though of a normal color. The rest of the glans was unchanged. The integument of the involved portion of the penis was not only much thickened and in spots brawny but also immovable upon the body of the penis, and had become developed into a multitude of nearly equal sized papillæ, which, though closely apposed to each other, could readily be separated, and were thus ascertained in many places to be nearly half an inch in length. Toward the root the papillomatous formation disappeared, and the usual brawny, irregular appearance of true elephantiasis presented itself, marked, however, by several openings through which urine and pus escaped freely on pressure, and also during micturition. But no urine flowed through the meatus at any time. From the meatus only a small instrument could be passed downward to a distance of two and a half inches, and was not then held by the grasp of a stricture,

but simply met an obstruction which was not to be overcome by flexible bougies, conical and otherwise. Nor could a probe or other instrument be passed through the fistulous openings into the urethra. The scrotum was normal.



The history given by the patient threw considerable light on his case. He stated that when he was eighteen years old he had gonorrhœa, but was readily cured, and experienced no trouble after that time until he was forty-four years old, that is fifteen years ago, when, being then actively engaged in lifting heavy logs, he passed blood from the urethra for several days and without much pain. On subjecting this point of his history to a closer examination, he acknowledged that he had had occasion to empty his bladder for some time previous to this more frequently than usual, and also at

night. After the hemorrhage ceased he noticed nothing further until four years after, when a painless lump appeared on the under surface of the middle of the penis on the right side, which remained quiescent for four years, when it opened and pus and urine came from it. Coincident with this nodule and resulting from it, he thought, the size of the stream of urine diminished, and after the urine escaped from the fistula in the penis it ceased to flow through the meatus, and has not passed through the latter opening since. With the discharge of the abscess came the slow enlargement of the penis, generally painless, though at times there would be more rapid but temporary enlargement, and then it was attended with pain. The growth in size did not advance much after the third year, and in the last three or four years but little change has occurred in the organ save that one urinary fistula would sometimes close and another break out elsewhere, generally in one of the sulci formed by the partial overlapping of the hypertrophied integument.

From these details it was probable that a stricture of long duration had been the cause of the hypertrophy — a stricture presumably of moderate calibre, and augmented by the inflammatory action excited by the laceration whence the hemorrhage came, and culminating in the formation of an urethral abscess from slight extravasation, and subsequent more or less extensive œdemas, repeated from time to time, and of a similar origin.

With this view of the case, and taking into consideration the involvement of the glans, together with his age and condition, amputation of the penis was advised and performed under ether, June 30th, by a single stroke of an amputation knife, about an inch anterior to the root of the penis, which was, after somewhat retracting the skin, pinched firmly and held by my colleague Dr. Sands. Three ligatures were applied to spirting vessels, one in each corpus, the urethra was slit on its inferior surface to the extent of half an inch, and the mucous membrane turned out and attached to the integument, creating thus, after the plan suggested by Ricord, Sedillot and Teale, a meatus capable of admitting the

little finger; the rest of the stump was closed by suturing the skin over the divided corpora caverosa.

The progress of the patient was perfectly satisfactory; from time to time a large sized sound was passed to insure due width of the new meatus, and prior to his departure from the hospital on the 2d of August, No. 30 (French) sound was passed with ease. He was moreover seen by me six months later, urination was easily effected, and No. 28 (French) sound readily entered the bladder.

The section of the specimen now in the hospital museum, showed the correctness of the conclusion.

The following is an extract from the records of Dr. Delafield, the Pathologist of the hospital: "The entire penis is enlarged. The skin over most of the body and glans is smooth but the prepuce and skin near it is covered with large papillæ. When the organ is laid open, the enlargement in size is found to be due to an increase of fibrous tissue in the deep layer of the cutis, producing a dense fibrous mass with, in places, hypertrophy of the papillæ. The urethra is completely closed at the middle of the penis, and the false passages already mentioned are also found."

There were also recognized the irregular vacuities called by Kaposi and others hypertrophied lymph spaces.

*Remarks.*—According to Kaposi,\* who has written an excellent summary on this subject, elephantiasis of the genitals ranks second in frequency, the order given by him being, a lower extremity (both, only rarely), external genitals, the upper extremities, the external ear, skin of the cheeks, the anus and lastly the female breast. Of the variety to which the above case belongs, but a few of anything like a similar size are recorded, and none so far as I have been able to investigate, having stricture of the urethra as a cause. Bryant,† however, gives one where the penis measured eight inches round and six long. The patient declined having anything done for it, being rather proud of it. He sought advice for the treat-

\* Hebra. 3d. vol. New. Syd. Trans.

† Surgery, p. 600.

ment of a gonorrhœa, though he admitted that he had never been able to have true coitus since the disease had existed, four or five years. Voillemier\* also describes a case where the sheath of the penis and prepuce were enormously hypertrophied, the organ reaching to the knees, and having a circumference of  $19\frac{1}{2}$  inches at its thickest portion, the glans and fraenum were, however, not involved and were hidden by the elongated prepuce which projected beyond the meatus urinarius more than a finger's length; the scrotum in this case was also invaded by the disease, but only to a moderate degree. The same author also reports, in the same journal, another case of elephantiasis affecting the prepuce.

In a lesser degree, the disease affecting the prepuce alone, it is not so rare. In Bergeron's *Thèse., De L'Elephantiasis des parties génitales*, several of the latter are given, and also a number of the more usual form where the penis and scrotum are coincidentally affected, but none where the penis alone was involved. The case of Dr. Thebaud,† where the enlargement of the scrotum and penis formed a tumor weighing some seventy pounds after its successful removal, is the most recent instance in this city of the more usual variety. Tumors of this kind, it may be said, reach even greater size than this, Wilks ‡ removing one of 156 pounds weight. Larrey § mentions one of over 200 pounds and Clot Bey's || largest tumor weighed 110 pounds.

Although not mentioned by any of our standard authors as even one of the rarer complications of stricture, yet in this instance the sequelæ of the urethral obstruction must be classed among "the local disturbances of the circulation and chronic recurrent inflammations of the vessels and lymphatics," assigned as causes by Kaposi in his definition of Elephantiasis Arabum. In the extremities he cites as important factors of this disease, chronic recurrent erysipelas and œdema. These, however, are rarely met

\* Annales de Dermatologie et de Syphiligraphie. No. 1. 1874.

† N. Y. Med. Journal, May, 1867.

‡ Titley, Diseases of the genitals of the male.

§ Larrey, Mem. de Chirurg. T. ii.

|| Lancet, 1831.

with in the genitals, and he adds to these causes a number of conditions that might maintain local hindrances to the circulation, thus embracing under this disease certain deformities, frequently called pseudo-elephantiasis, two notable instances of which have lately occurred at St. Luke's Hospital, one resulting from long continued pressure on the popliteal vessels by marked luxation in chronic strumous synovitis, and the other from necrosis of the tibia.

It is proper to add here in reference to the treatment adopted, that, under circumstances where the general health, age, etc., were more favorable, the surgical procedure successfully resorted to in Voilleimer's case, of removing the greater portion of the mass inferiorly and laterally, and covering the penis with flaps from the scrotum, even though they were made out of the diseased tissue, might be resorted to. For he and others have observed that this does not form a focus for new development, and in the present case a portion of the covering of the stump was formed of thickened tissue, which subsequently shrunk to a natural condition.

19 EAST THIRTY-SECOND STREET, N. Y.

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## HINTS ABOUT TERTIARY SYPHILIS.

BY CHARLES R. DRYSDALE, M. D.,

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THE subject of tertiary syphilis is one which has not been so elaborately treated as that of primary or secondary syphilis. That unlucky division of medical practice in hospitals, into medical and surgical, has been the main cause, I presume, of this notable fact. Surgeons, not excepting the great

John Hunter, are so much occupied with diseases which require operative procedures, that they are not so ready to take an interest in diseases such as tertiary syphilis, which are not amenable to operations, but solely to medicinal agents. In Paris, this has been so much felt that, since the days when M. Ricord left the Midi Hospital, there are now two physicians, in place of two surgeons who formerly carried on the service; and the same occurs at the Lourcine Hospital.

In London, as yet, the syphilitic wards of hospitals are still under the charge of operative surgeons; and hence, our best works on tertiary syphilis are as yet only to be found in France.

*Proportion of cases of Tertiary Syphilis.*—It is well known by all persons who have for many years watched cases of secondary syphilis, that a large proportion of all cases of syphilis exhibit no tertiary symptoms. It would be premature to state the exact number of persons with secondary rashes, who may expect to have some form of tertiary lesion; but I think that rather more than the half of patients I have treated have not had any such symptoms, as far as I have followed up their cases.

As a general rule, tertiary lesions do not occur before the end of the first year of syphilis, and far more frequently at the end of the second year than in the first. The rashes of secondary syphilis are apt to last for eighteen months or two years. On the other hand, tertiary lesions may occur at *any* epoch after the early chancre or rashes. Ten, twenty, thirty, or even forty years of health may elapse and then the patient may have some alarming, nay, fatal, syphilitic lesion. It is for this cause that syphilis is such a grave disease, and that it has been justly styled by the renowned Ricord “the greatest plague of the nineteenth century.”

*Causes of Tertiary Syphilis.*—This is perhaps one of the most obscure points in the whole history of syphilis at this moment. Doubtless, scrofula or phthisis in the family history of the patient who is attacked with syphilis is a very predisposing cause to tertiarism. Old age, I also think, predisposes to severe

forms of both secondary lesions and tertiary disease. Some authors will have it, that the use or non-use of mercury, during the early epoch of the disease, is the chief cause of the supervention of tertiary disease; and on this account are strenuous in urging on all practitioners to administer long and careful courses of mercury in ALL cases of syphilis. Others, again, consider that tertiary syphilis only occurs, when some constitutional dyscrasia exists favorable to the ravages of the poison; and maintain that its occurrence is not prevented or caused by courses of specific medication. On this very important point much more requires to be observed and written. On the one hand, it seems clearly of importance to guard against administering a twelve months' course of mercury to all patients with true syphilis indiscriminately, when it is ascertained that rather more than half of such patients, if not treated at all with mercury, would not be liable to tertiaries.

But, there is as yet no way of ascertaining what class of secondary rashes are apt to be followed by tertiary lesions and what are likely to be exempt; and, hence, the question now is, how long mercury ought to be used for the purpose of preventing the possible occurrence of the dangerous period of tertiary lesions.

M. Ricord proposed a six months' treatment, with one grain of the green iodide of mercury daily, in the secondary period. His pupils, as Edward Fournier, propose interrupted courses of the same prescription, for six weeks at a time, during a period of two years, as the treatment most likely to prevent the occurrence of tertiary lesions. Time alone can give a reply to these questions.

With respect to scrofula, I have not a doubt that tertiary syphilis is occasionally rendered almost intractable by the constitution of the patient being consumptive or scrofulous. In several patients of consumptive stock, tertiary lesions have recurred again and again, year after year, until at length the patient has been carried off by phthisis or some other intercurrent disease.

*Diagnosis.*—The diagnosis of tertiary syphilitic disease is often

most obscure. In ancient days it used to be said: "*In dubio, suspice venerem,*" and at present the same adage is not without its value. I have very often seen cases of chronic Bright's disease and paralysis, which other practitioners had put down to ordinary causes, but in which I made up my own mind as to some syphilitic causation ere long.

Few tertiary syphilitic lesions have any thing distinctive or pathognomonic about them. Liver or kidney disease, for instance, when syphilitic, is not easily diagnosed. The tertiary lesion is generally solitary, and no other syphilitic symptom is present. As to syphilitic antecedents, these are usually wanting, especially in women, who on this point are either secretive or ignorant of the nature of their disease.

The lesion may occur at a very distant epoch after the occurrence of the primary disease, and in certain classes of events it seems often indecent to suspect syphilis. For instance, when the father of a large, fashionable family is seized with hemiplegia and aphasia, it would often seem out of the question to think of such a man having contracted syphilis, were it not that such cases are not unknown.

The *Prognosis* of tertiary syphilis is a grave one. Far more people die of tertiary lesions, than the mass of the profession has, I believe, any conception of. When tertiary syphilis has made its appearance, we may be prepared for paralysis of any nerve, or kidney, lung or liver disease in our patient, not that these *will* occur, but that they *may* occur at any period of his after life. In the case of women too, tertiary syphilis may coexist with the loss of all their children at birth or shortly after birth.

*Treatment.* — Tertiary syphilis, fortunately, is more influenced by drugs than either primary or secondary syphilis. Iodide of potassium is, as Mr. Ricord has always maintained, *the remedy* in tertiary syphilis. This is the most incomparable of all therapeutic agents at this stage of the disease. Not that even this remedy always cures the lesions caused by tertiary syphilis. Certain obstinate cases will

resist even this potent drug, but they are rare exceptions. The cases in which iodide of potassium fails to cure are indeed deplorable cases of tertiary syphilis, and for the most part they prove fatal in the end. Of course, we cannot expect iodide of potassium to cure the lesions of the brain already caused by some gummy tumor or restore the skin already destroyed by some sloughing ulcer. In some cases again, we are always curing our patient, and the disease eternally relapses. I have had cases of tertiary sore throat where the patient returned with alarming symptoms in the fauces for ten or twelve years, the intervals of comfort being perhaps not more than a couple of months at a time.

*Gummy deposits.*—Since the very clear account given by Virchow of gummy deposits, the profession has begun to understand the way in which tertiary syphilis commits such ravages in the tissues. Gummy tumors have several stages. In the first they appear as tumors, hard, solid and not inflamed. These tumors then soften, fluctuate, and become dusky red, then open and ulcerate, and a slough comes away, composed of the skin and cellular tissue. Next follows the cicatrisation of the ulcer.

It is very rare that more than two or three such tumors are seen on the same patient; and the tumors rarely exceed in volume the size of a hen's egg. There are instances on record in surgical works, where such tumors have been removed, as the tumor has exceeded the size of the foetal head and been taken for a malignant one.

*Diagnosis.*—In making up our minds as to the nature of a gummy tumor, three orders of facts have to be taken into account; the consideration of the antecedents, the other symptoms present, and the aspect of the ulcer or tumor. Now the gummy tumor or its ulcer presents no appearance, which is quite pathognomonic, but several very special. It is a tumor which was at first hard, then softened, and lastly ulcerated. It resembles, however, in some respects all solid tumors, such as cancer, adenoma, or others; and is sometimes like scrofula or simple ulcers.

Gummy tumors have several very important points of diagnosis which distinguish them from cancer. In the first place, cancer is far more frequent in old persons than in young, whilst the gummy tumor has no age peculiar to itself. In cancer, there is but one tumor; in the gummy tumor, sometimes more, and the gummy tumor is usually small in size whilst cancer may be large. Then, again, the cancerous tumor adheres to the skin, and the gummy tumor is non-adherent and irregular in form. There is pain in cancer and no pain in gummy tumors. The glands are affected in cancer and not so in gummy tumor. The iodide of potassium has no effect on cancer, but cures gummy tumor. It is quite miraculous to see how rapidly they are cured by the iodide.

As to the treatment of gummy tumors, wherever situated, first of all, they require no interference with the knife, and the same may be said of cautery. Nor need we trouble to incise such tumors, when they fluctuate. All use of cautery may be laid aside and large doses of iodide of potassium alone made use of; as much as half a drachm may be given in one dose. Rarely indeed shall we require to call in the aid of mercury or any other drug, and mercury should only be used when the iodide has been tried in its dose and failed. When the gummy tumor becomes an ulcer, it ought to be treated by softening poultices and some stimulating wash, such as *lotio plumbi*.

*Tertiary Affections of the Nerves.*—Patients often apply at hospitals who are suffering from some nervous disease, the antecedents of which have been quite unrecognized as specific; and whose disease is much ameliorated (in some cases cured) by specific remedies. The diagnosis of disease of the nerves dependent on syphilis is often obscure; but the grouping of the symptoms points to the nature of the case.

The age of the patient is a further help to diagnosis, for the great majority of cases of paralysis seen in young adults are seemingly due to the poison of syphilis. If a case of palsy in a young man over 20 and under 50 comes before us, it is well to try the

effect of specific remedies, unless some very evident cause be present.

Epilepsy, too, in persons of that age, is frequently syphilitic in its causation; and is better treated by iodide than by bromide of potassium. In such cases of epilepsy, the pain in the head will often be found to precede the fit, whereas in idiopathic epilepsy, headache follows the fit. Then the attacks of ordinary epilepsy commence generally at puberty, whilst those of syphilitic epilepsy come on after 20. Complete loss of consciousness is not so frequent in the syphilitic cases as in ordinary epilepsy, and the spasms are unilateral in syphilis in many instances. Many fits may supervene in rapid succession, with intervals of coma, and this may be followed by loss of power on one side.

In cases of hemiplegia from syphilis the patient does not often lose consciousness. The gummy tumor may exist in the skull, the vessels, or meninges of the brain, or in the texture of the brain itself. When the corpora striata are affected, the hemiplegia is most marked.

Syphilitic inflammation and gummy tumors occur also on the cord and cause paraplegia. The sensation of constriction round some part of the body points to disease of the cord.

Vertigo is commonly complained of in syphilitic brain disease.

With respect to diagnosis, hemiplegia, accompanied with palsy of one of the cranial nerves, or with paraplegia, is commonly syphilitic; so is amaurosis with convulsions.

Patients with syphilis of the brain are apt to have fresh attacks of the disease from time to time; and hence, a certain portion of the dementia seen in lunatic asylums is due to tertiary syphilis. Such cases end fatally ere many years pass by. Esquirol remarks in one of his works, that insanity, combined with paralysis, soon proves fatal. Many such cases are of syphilitic origin.

## CLINICAL NOTES ON LICHEN PLANUS.

BY R. W. TAYLOR, M. D.,

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MY object in presenting this paper is to call attention to the existence of a somewhat peculiar skin disease which, though recognized as occurring rather infrequently in England, has not, to my knowledge, been observed and described in America. The description of it was first carefully given by \*Wilson of England, and it is in consequence of his writings that it has been accepted as a distinct form of lichen, which that writer, from one of its distinguishing features, has called *lichen planus*. It has been my good fortune to meet with four such cases at the Skin Clinic of the College of Physicians and Surgeons, and under the circumstances I have thought them worthy of publication. I am led to believe, from conversations with persons who see large numbers of skin diseases, as well as by reference to published statistical tables, that it is not of frequent occurrence, and the fact that during a period of eight years we have had but four cases at the College Clinic, also supports that view, and †Wilson, in speaking of the rarity of its occurrence, says that he met with fifty cases among ten thousand miscellaneous cases of skin disease. Perhaps when attention is called to the trouble, other observers will meet with and report cases. I am indebted to Prof. Wm. H. Draper for permission to use the cases.

*Case 1.*—Sarah Sexton, aged 30, a domestic, of healthy parentage, had always been perfectly well. She was a maiden, and had never had any disturbance with her menstrual functions. She was well built and tolerably stout. She had never before had any eruption upon the skin, and her family was said to have been free from such. In February, 1870, she noticed that an eruption

\*Journal of Cutaneous Medicine, vol. 3, page 117; 1869.

†Journal of Cutaneous Medicine, vol. 3, page 121. 1869.

appeared upon the inner aspect of the left fore-arm, which soon became developed upon the inner aspect of right arm, and then slightly upon the outer aspect of each. In a week the same eruption following a similar course invaded the thighs and legs. She described the itching as being intolerable, and said that when she looked at the spots that they appeared like little glittering heads, and that they were slightly star shaped. She suffered with the trouble, using simple domestic remedies, for a month, when she applied at the college. The patches of eruption upon the inner aspects of the arms were larger than those on the outer, and were confined chiefly to the middle thirds, though extending in a scattered form slightly beyond, not going below the wrist, however. They were about six inches in length and three in width. Those on the outer aspects were about four inches long by two wide. The distribution was similar upon the thighs, but on the legs it was chiefly seated on the inner and anterior aspect, being here rather sparse. Between the large patches upon the arms and legs small groups and isolated papules were to be seen, together with spots of healthy skin. There were also a few irregularly scattered papules upon the abdomen. There were evidences of the parts having been scratched, but the lesion had not been at all obscured by the act. A minute description of one patch will answer for all. Toward the periphery were to be seen papules of varying sizes, from that of a pin's head to a line in diameter, a few being even two lines in diameter. These papules were quite flat, elevated in their maximum to a height of about one half of a line and in some, the largest ones in particular, a slight depression of the centre was seen. Rising quite abruptly from the plane of the integument they were quite angular at their edges and did not round off in the manner observed in some forms of the syphilitic papule. Their shape varied, some, especially the largest, were angular and even slightly star shaped, others merely round, the smallest being of the latter form. Their color was peculiar, being of a pronounced purple or violaceous hue. The smallest, however, were red and as they increased in size it was noticed that the purple tint became more marked. The redness, however, was not bright but rather deep. In structure they seemed composed of firm epidermal tissues and they were evidently developed in the superficial portions of the derma and the subcutaneous structures were not involved, there being

no œdema. Indeed, in pinching the skin it was clearly perceived that there was very little infiltration, if any, in the subcutaneous structure. The amount of scaling was very slight, though it was evident by the fissures through the superficies of papules that there was an abnormally thick epidermal layer, this latter was quite firmly adherent and very little desquamation occurred; while the surface of the majority of the papules was flat, upon that of others a very slight depression was present, which corresponded with the orifice of the follicles. In some exceptional instances a perceptible thickening of the tissues just around a follicle from which a hair arose was seen. In many of the smallest papules it was evident that their origin was in the tissues immediately around the follicles, as there was a well marked, but, of course, very minute central depression. As said before, there were slight and superficial fissures through the epidermal layer of the papules, and their aspect was peculiar being glistening in color, or as Wilson describes, having a mica-like appearance. The fissures were chiefly developed in the surface lines of the skin. The violaceous color, the micaceous film and the slight fissuration were the peculiar and striking features of these papules. Then also their somewhat angular outlines and flat surface, also contributed to the whole aspect. If the surface of the papules was examined by pricking with a sharp instrument, it was readily perceived that the micaceous covering was quite adherent and indeed that very little of it passed away in desquamation. Indeed, as remarked by Wilson, about his cases, this process did not seem to be active as there were at the most a few scales which were breaking off from the surfaces of papules generally, but there was no evidence of abnormally active epidermal proliferation. In some parts of the patches mature papules had fused together, still if carefully examined, their contours could be made out. Others again, had undergone full development, and were subsiding and being slightly raised above the plane of the integument, they consisted of a somewhat thickened epidermis with the peculiar appearance already described. Again, there were spots in the center of the patches where no papules were present, but the skin, not at all thickened or desquamative, was very darkly pigmented. This pigmentation was of a dark brown or coppery appearance similar to that observed after the subsidence of syphilitic lesions of the skin. The distribution of this discol-

ation was in some places in the form of large patches and in others in the form of spots about the size of the largest papules; the patches being in the centre, the smaller spots toward the periphery. To complete the picture it is necessary to add that pigmented skin occupied nearly the centre of the morbid patches, the larger papules were distributed immediately around it and the smaller or developing papules were at the extreme periphery. Amidst the small papules were minute erythematous spots, the evident stage of development of those lesions. Some of these spots seemed to be situated around the hair follicles. Such were the minute and general features presented by the eruption. When the pigmented skin was pinched up in folds, no perceptible thickening was felt.

Inquiry into the condition of health of the patient gave no explanation as to the cause of the eruption, and except that she was somewhat debilitated and that her urine was scanty and contained abnormal quantities of urates and oxalate of lime, there were no pathological indications upon which to base a constitutional treatment. She was ordered to take, three times daily, thirty grains of citrate of potassa, with five of citrate of iron and quinine, dissolved in a wineglass of water. The local treatment consisted in the daily use of warm alkaline baths with frictions twice daily, with the *tinctura saponis cum pice* of Hebra. To alleviate paroxysms of itching, she was supplied with an ointment consisting of simple ointment one ounce, oil of cade one drachm, and powdered camphor two drachms. It was suggested to her to keep the parts smeared with this ointment during the intervals of application of the tincture, but owing to her occupation she could not fully follow out the advice. Under this treatment the eruption rapidly subsided, and in three weeks had disappeared, leaving the peculiar pigmented stains. I observed that the patches which were composed of small undeveloped papules were not as much pigmented as those were upon which the mature papules were seated. This is explained by the fact that the congestion was of shorter duration in one place than in the other, and that the inflammatory processes not having gone on to full development had been cut short by treatment. In order to know how long this pigmentation of the skin would continue I followed up the case carefully, and found that it disappeared very slowly, and that six months elapsed before it had fully disappeared. There was

then no trace of pre-existent lesion, though the patient stated that she had suffered from slight pruritus of the parts formerly affected for some months.

*Case 2.*—Elizabeth B., aged 61, a thin, delicate woman came to the college on the 9th of October, 1869. She had been the mother of a family and during her life she had enjoyed average health, of late years she had suffered from chronic rheumatoid arthritis. She had never before had an eruption of the skin, and she thought that her family had been free from such. During the latter years of her life, she had been very poor and had lived on a scanty sustenance, which she obtained from friends and from a religious charity. Three months before her application at the college, she had experienced intense pruritus in the fore arms and thighs, and she soon observed an eruption, which she spoke of as glossy spots. Beginning quite locally in a patch about two inches in area, the eruption had gradually invaded the greater part of the fore arms, involving both inner and outer aspects, more thickly the latter, however. Upon examination, I found an eruption of papules which presented all the features of case No. 1, there being no variation except that in this case it was rather more copious. There were the same papules in all stages, and in the central portions pigmented spots. The eruption increased at its periphery by the development of more or less isolated papules, and it was evident that the arms would soon be the seat of a similar eruption. The history of the woman indicated debility as the probable cause of the eruption, perhaps aggravated by her arthritic diathesis. She was treated after the manner of case No. 1. Her eruption ceased to extend after the commencement of treatment, and it had disappeared at the end of a month. In this case, as the woman ceased to attend a month after the cure, I was unable to observe as to the persistency of the pigmentation. When last seen, little, if any, change was to be noted.

*Case 3.*—Amelia H., an enormously fleshy woman, the mother of a large family, came to the college October 5, 1870. She had enjoyed good health during her life, but had suffered from an acid dyspepsia. A month previous to her first visit she had experienced great itching upon the arms, shoulders, over the hypogastrium, buttocks, legs and feet. She soon noticed an eruption, and when examined it was found to present the same features as the two previous cases. She was ordered to take thirty grains of

acetate of potassa thrice daily, to use baths and the same external remedies as the other cases. The result of treatment, however, was not as satisfactory, for at the end of a month, there was very little change in the appearance of the old eruption, and new papules were seen developing. It so happened that Prof. Boeck of Christiana had called, by invitation, at the college, and the case was shown to him. He said that he thought that it would be benefited by such agents as would supply large quantities of oxygen to the blood, and suggested that she should take twenty grains of chlorate of potassa in about four ounces of water, fifteen minutes after each meal, and twenty drops of dilute nitric acid in a wineglass of water, fifteen minutes after the potassa. The result of this treatment was remarkable, as at the end of a week marked amelioration had occurred in the pruritus, which steadily decreased. Coincidently the papules subsided, no new ones appeared, and in six weeks the woman was well. In her case the eruption was very copious, and being a very large woman, there was much of it. It was particularly thick on the dorsum of the feet and near the instep, and impeded locomotion very much. Her abdomen was very large and pendulous upon the thighs, and upon these coapting surfaces the papules, particularly the largest ones, owing to sweat, assumed somewhat the appearance of mucous patches, but they did not become excoriated, nor did they secrete any fluid. The manner in which this case was benefited by this treatment was remarkable. It certainly goes to prove that there are at least some skin lesions which have as their origin an internal cause. As regards the eruption, it presented the same general features observed in the other cases except that at the instep the papules formed quite large patches or plates, and the fissures were deeper than elsewhere.

*Case 4.*—Leopold K., aged 38, clerk, came to the college October 27, 1873. He stated that he had always been perfectly healthy, had never had any lesions of the skin, and that he knew of no cause for his present trouble. Inquiry as to whether he had become debilitated during the summer, developed the information that such was not the case. He stated that two weeks prior to his visit, he had experienced itching about the arms and shoulders, and that soon a rash was observed. This condition, in a few days, involved the trunk, and almost at the same time, the legs were attacked. He did not feel at all sick during the evolu-

tion of the rash, and he stated that he did not think that he was feverish. The temperature was found to be normal. Upon examination, I found that the greater part of the body was covered with the peculiar papules already described. There were regions, however, such as the prominence of the shoulders, the buttocks and the inner aspect of the arms where they were more numerous. There were also some few papules upon the palms, none on the soles. The papules in this case were not as large as in the other cases, but they presented the same features as the others. When the man was examined in a nude condition, the peculiar glistening and dead-red or violaceous color of the eruption presented a strange appearance. There was rather more inter-papular erythema in this case than in the others, and this condition gave the eruption the appearance of being more extensive than it really was. There was no infiltration whatever. When the hand was passed over the skin, it was found to have a dry and smooth feel, and it was evident that the man did not perspire very much. When asked, he said that he did not. The sensation given to the touch when the hand was passed over the skin, was similar to that given by a soft smooth piece of leather, thus examined. There being no error of the economy to account for the eruption, the treatment consisted in the administration of an alkaline diuretic, namely: potassa acetate, gr. xxx, three times a day, with two cathartic pills every second day for a constipation which existed. Locally alkaline and bran baths were administered every night the body having been rubbed two hours previously with the *tinctura saponis cum pice* of Hebra. This was rubbed into the skin in the morning and then the patient without washing it off protected his clothing by means of soft cotton under-shirt and drawers. The relief to the man's suffering was immediate, and it was readily seen that the eruption was benefited. This line of treatment was followed with great care by the patient for five weeks, at which time he was considered cured. His appearance then was striking, as the mottling of the skin, or rather its quite general pigmentation gave him a brown color much darker than normal. During the whole period very little, if any, desquamation occurred. The patient has remained well since. The pigmentation disappeared in three months.

I think that these cases can certainly be classed as belonging to the affection which Wilson calls *lichen planus*, and

which he thus graphically and succinctly describes: "Lichen planus is an eruption of pimples remarkable for their color, their figure, their structure, their habits of isolated and aggregated development, their habitat, their local and chronic character, and for the melasmic stains which they leave behind them when they disappear." Going on he alludes to their crimson or lilac tinge, their figure, structure, etc. The evolution of these papules will be seen to be rather slow in three cases and quite rapid in the fourth, so it is fair to presume that both of these conditions will be found again. Wilson speaks of an unsymmetrical development of the rash, this was not observed in my cases. He further speaks, quite fully, of the discrete and aggregated distribution of the papules, both of these forms could be quite well observed in three of my cases. In but one were the palms affected and here the papules were very ill defined, and did not have the peculiarities of the general eruptions. Considering the great extent of the eruption in case No. 4, it is somewhat singular that constitutional symptoms were not present, and I am induced to look upon this absence as a diagnostic point between the present eruption and the erythema. It is interesting to know, as proved by two of my cases, that the melasmic staining or pigmentation of the skin is not permanent, as this might become an interesting question to be settled for the patient. As this paper is intended chiefly to call attention to the existence of this eruption, and as a systematic description has already been given by Wilson and by Tilbury Fox, I shall not enter into the matter of diagnosis. I would say, however, upon the question as to whether this is an eruption *sui generis*, that, in my opinion, it is. Certainly its features, course and decline, and the condition of the skin after its subsidence, point clearly to the fact that it is not a form of eczema, so manifest is this that comparison is wholly unnecessary. The same remarks apply to the supposition that it is a form of erythema, and I have already, in an article upon the papular syphilides,\* called attention

\* Observations on the Papular Syphilides, American Journal of Syphigraphy and Dermatology, April, 1870. Page 114.

to the differences to be observed between syphilitic papules and those of lichen planus. As to the etiology of the affection, two of my cases are of value as suggesting probable causes. In the second case, that of the old woman aged sixty-one, debility from want of proper food, a condition perhaps qualified by the well demonstrated arthritic diathesis, was undoubtedly the cause. In the third case, in which so much benefit was derived from the active administration of agents yielding oxygen to the blood, there is perhaps cogent evidence that the eruption arose from some error of assimilation, upon which there are so many chemical theories, but which as an entity certainly exists in some cases. The case as an evidence of the occasional striking value of therapeutics is certainly an instructive one, and as a prototype it may be of benefit in this connection. Whether errors of assimilation existed in cases Nos. 1 and 4, I am unable to say. In the first there was scanty secretion of urine and copious deposit of urates, conditions improved by alkaline diuretics with coincident improvement of the eruption. In the former case, there being no demonstrable error of any of the functions, it is questionable how much benefit the alkaline diuretic produced, as the topical treatment was certainly of a character and of sufficient activity to cause a subsidence of the eruption. From this case I think no therapeutical deductions can be drawn. Wilson thinks that this skin affection is similar to the *lichen ruber* of Hebra. My friend, Dr. Fox, whose\* description in the last edition of his work is admirable, thinks that the form in which the rash is general, is similar to Hebra's disease, and my studies in my fourth case which was of this variety, lead me to the same conclusion. It is certain that the two forms which are well illustrated by my cases, namely, the localized and the general, are examples of the same disease, and this leads me to think that it perhaps reaches a greater intensity in Austria than in England or America. This is a point often noticed in other diseases. As this article is merely a contribution to the subject, I would suggest to those to whom it is new to consult the excellent descriptions of Wilson and Fox.

\* Skin Diseases, London, 1873, p. 144 *et seq.*

## THE FREQUENCY AND VARIETIES OF URTICARIA.

By HOWARD F. DAMON, M. D.,

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ALTHOUGH neither a fatal nor dangerous disease, its numerical importance entitles urticaria to a more attentive study than it has hitherto received from physicians or dermatologists. According to my observations in hospital practice, in six thousand cases of cutaneous disease there have been nearly three hundred cases of urticaria.

The different varieties of urticaria depend either upon the elementary lesion or the course of the disease. As regards the elementary lesion, we have that condition of the skin which gives rise to wheals, or is susceptible of their artificial production, without those subsequent changes which we are about to describe. Next in order, among the varieties of urticaria, is the lichen urticatus of Willan, more properly denominated urticaria papulosa, in consequence of the wheals terminating in papules. Where there is much serous infiltration of the derma, the condition is produced which is very properly known as urticaria tuberosa. The wheals may extend in an eccentric manner, so as to form portions of circles or wavy, serpiginous elevations. This form of urticaria has been denominated urticaria perstans vel annulata. When the exudation is so superficial and in such quantity as to detach and raise the epidermis from the subjacent tissues, so as to form vesicles, we have a variety of the disease designated urticaria vesicularis, more properly urticaria vesiculosa. If a bleb or bulla is formed, the case is considered an urticaria bullosa. Hemorrhage occasionally, although very rarely occurs in the bullous form of urticaria. This variety has been named purpura urticata by Willan. If we wish to preserve euphony as well as system in our nomenclature, the name of urticaria hemorrhagica would be more appropriate. Nevertheless, it is uncertain whether this variety

of disease requires a distinctive name; since hemorrhage takes place, under certain conditions, in many of the acute eruptions of the skin.

More or less pigment may be deposited in the epidermis and derma in consequence of extravasations of blood or the irritation of the rete mucosum. In such cases, we have brown, circular, more or less permanent patches.

The piliferous follicles may be unduly stimulated, and, as a consequence, excessive growths of lanugo, or tufts of hair, may occupy the sites of former wheals. We shall presently cite a case of this kind.

Thus far we have only considered the physical changes which are obvious in the different varieties and complications of urticaria; or the purely objective features of the disease.

The course of urticaria is evanescent, persistent, or recurrent. Thus we have the varieties known as urticaria evanida, perstans and recidiva. The persistent variety usually assumes the annular form. The evanescent variety is either a simple circular, oval, or lineal wheal, or a wheal terminating in a papule. The recurrent variety returns in either of the forms just mentioned, but at regular intervals and at particular times in the day.

As we propose in this paper to treat only of the frequency and varieties of urticaria, the production of the different lesions and their causes will receive but casual notice.

The evanescent varieties are produced both by vaso-motor and nutritive changes in the skin, of temporary duration. In the papular, annular, tuberose, vesicular and bullous varieties, there are more prolonged vaso-motor and more extensive nutritive changes. Redness, serous exudation, hemorrhage and pigmentary deposits are the results.

As regards the frequency of this disease, we have observed two hundred and eighty-six cases of urticaria in about five thousand and eight hundred cases of cutaneous disease. Fifty-four of these cases belonged to the general urticarial condition of the skin

where the wheals disappear without leaving any papular or other change. One hundred and fifty-one cases were of the papular variety; and twenty-one cases were attended with the formation of bullæ. There were six cases denominated annular, and four perstans. The recurrent variety was observed in fifteen, and the evanescent variety in twenty instances. The following outlines of cases will serve as illustrations of this subject:

*Case 1. Urticaria annulata et bullosa.*—James H., aged 11 months, was brought to my clinic, April 6, 1869, having suffered from attacks of urticaria for a period of three months. The eruption had assumed the form of elevated and annular wheals, more numerous on the extremities than on the body. Several bullæ were developed on the palmar and plantar surfaces. Some of them were of the size of a split pea. They contained a cloudy serum in which there was some pus. The itching of the skin was intense, new wheals were constantly being developed. The child, although very restless, nursed well, and his general condition appeared good.

*Case 2. Urticaria papulosa et pigmentosa.*—Thos. F. B., aged 3 years, has suffered from lichen urticatus at different times since an infant. The eruption of urticaria at the time of this visit was quite general. Many of the wheals, on disappearing, had left yellowish or brown papules and oval patches on the skin. These pigmentary patches were from half to three-fourths of an inch across.

*Case 3. Urticaria recidiva.*—Hannah D., aged 20 months, was brought to my clinic, July 8, 1869. During the last four months the patient has been subject to very frequent and regular attacks of urticaria, there being intervals when the disease entirely disappeared. At the time of this visit, there were numerous oval and circular wheals with white, elevated centres, distributed over the body and extremities. The child was pale, and had a poor appetite.

*Case 4. Urticaria evanida.*—James McN., aged 11 months, was brought to my clinic, July 26, 1869. For two or three days previous to this visit, the little patient had suffered from repeated eruptions of wheals of evanescent duration. At the time of the visit, the wheals were to be seen on the face, body and extremi-

ties; many new ones replacing those which were about to disappear. The child had been troubled with diarrhoea and vomiting for the past four days.

*Case 5. Urticaria papulosa.* — Lizzie O'H., aged 9 months, was first seen July 31, 1869. This extremely young child has been affected by an urticarial eruption for the past three or four weeks. The wheals made their appearance in the form of red patches with white centres. When these wheals subsided, papules were left in their places. They were very itchy, as was shown by the restlessness of the child, and its apparent attempts to rub or scratch its face and arms. The eruption occupied the face, body and extremities.

*Case 6. Urticaria papulosa, pigmentosa, et pilosa.* — Hannah M., aged twenty months, came under observation August 24, 1869. This little patient had suffered from repeated attacks of lichen urticatus, or urticaria papulosa, for the previous four or five months. The wheals were distributed, at the time of the visit, on the body and lower extremities; there being only a few recent ones, situated on the arms and fore-arms. Many of the wheals had been excoriated by the efforts of the patient to obtain relief, either by rubbing or scratching them. In several of the sites of former wheals, there was a considerable deposit of pigment. Tufts of hair, or lanugo, of about an inch in length, had grown upon the circular excoriated patches on the left arm, the sites of former wheals and papules of urticaria. The hair was thickly set, quite stiff, dark brown, and resembled the coarse lanugo on the arm or chest of a man. There were no such excessive growths of lanugo on the right arm, or on the lower extremities.

*Case 7. Urticaria papulosa, bullosa et pustulosa.* — Jos. D., aged one year, came under observation at my clinic, September 6, 1870. During the past six weeks the patient had been suffering from an aggravated form of urticaria. The eruption was on the face, the extensor surfaces of the fore-arms and backs of the hands, also on the fore parts of the legs. There were no wheals seen on the body. Some of the wheals were succeeded by papules, while others gave place to bullæ and sero-purulent collections. On the face and scalp, there were several furunculi.

*Case 8. Urticaria papulosa, vesiculosa, et bullosa.* — Louisa D.,

aged three years and ten months, was brought to me May 27, 1872. She had been suffering about a week from an eruption of urticaria. The wheals on her cheeks terminated for the most part in the formation of papules. In some instances, there was an eruption of small vesicles on the central and previously white portion of the wheals. On the ulnar border of the right hand a considerable bulla had formed. The itching was very severe during the whole night. Oval and elongated wheals were on the thighs. The patient was quite pale; and reported to have recovered from measles two weeks previous to this visit.

*Case 9. Urticaria papulosa, vesiculosa, et pustulosa.*—Annie M., aged three years and six months, was brought to my clinic July 25, 1872. This patient was first attacked with urticaria in the month of May. The case was supposed to be varioloid, as that disease was somewhat prevalent in Boston; and the patient was sent to a small-pox hospital, where she remained four days. The phenomena of the disease not answering to those either of variola vera or variola modificata, the patient was discharged, and finally came under treatment at my hospital clinic. There was an eruption of wheals of well-marked character on the face and extremities. They were oval and circular, and in all stages of development and retrogression. Some of them were surmounted by vesicles, while bullæ, and even pustules had formed on others.

## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. BULKLEY.

*Fifty-fourth Regular Meeting, February 3, 1874.*

DR. KEYES exhibited a patient with *Dactylitis syphilitica* of unusual form. The boy, aged 16, in fair health, but badly nourished, is next to the oldest and considered the healthiest of six children. From earliest recollection he has had more or less of disease of the hands and feet, commencing generally in what appear to be dermic abscesses, but which were followed by the present disfigurement. No real syphilitic history can be obtained from him or his mother. The other children were said to have no eruptions.

Both hands and both feet are affected and considerably disfigured, some of the phalanges seem shortened, others lengthened, as also some of the metacarpal bones, the right hand being most markedly affected. On the skin there are evidences of preceding new deposit and ulceration, in cicatrices and elevated red patches and lines. The boy has taken cod liver oil most of his life, with little benefit, but a mixed anti-syphilitic treatment is now causing considerable improvement in those portions of the cutaneous lesion which are still in active change. The question was, as to the true nature of the difficulty, if syphilitic, whether hereditary or acquired? Dr. Keyes was inclined to attribute the lesions to acquired syphilis, as he thought that the manifestations of congenital syphilis would have appeared earlier than they did in this case. The rash, etc., of acquired syphilis might easily pass undetected, whereas it would be hardly possible for a child to have had congenital syphilis which would thus develop without the earlier symptoms having been noticed.

Dr. OTIS criticised Dr. Keyes' remark that the symptoms of congenital syphilis would necessarily have been noticed, as we have here to do with an uneducated mother, while it often happens that even physicians fail to recognize the disease; mentioning a case where with five concurrent manifestations of syphilis, a physician was in doubt as to the diagnosis. He believed that the present case was one of syphilis, probably acquired, and should certainly give specific treatment.

Dr. WEISSE regarded the case as undoubtedly syphilitic, and thought the disease had been acquired, as it was reported that no other child was affected. The symmetrical development was a marked feature, pointing to syphilis.

Dr. STURGIS doubted if the syphilis was acquired, which does not necessarily follow because others of the family were not affected. The mother may have gotten well between this child and that next younger, more than a year had elapsed. The lesions he considered rather those of hereditary than acquired syphilis. If the disease were contracted, when and how did he get it?

Dr. BRIDDON asked if the child had ever nursed any one but his mother? Answered in the negative.

Dr. FOX was inclined to regard the whole trouble as a scrofulide, or a lupus, although he questioned as to whether true bone disease could result from lupus; this feature looked more like syphilis, but the other aspects of the case were to him rather those of lupus. He called attention to the fact that the lengthening of some of the bones was more apparent than real, being caused by the shortening of adjacent members.

Dr. STURGIS suggested that the great involvement of bone would exclude lupus and narrow the disease to a true scrofulide or a syphilitic manifestation.

Dr. VAN BUREN regarded the disease as syphilitic.

Dr. TAYLOR believed the case one of hereditary syphilis, and mentioned an instance where the meta-carpal bones were attacked as late as during the third or fourth year. He remarked that the later manifestations of congenital syphilis (as also in the acquired disease), were caused by a gummy deposit or infiltration, which produced swelling and afterward absorption of the bones. Lengthening also may occur from the attendant inflammation. He thought that treatment could *not* be considered the touchstone of

diagnosis in this late stage of syphilis, as it is in the earlier periods. A degeneration has taken place, and a local lesion remains. The treatment would be tedious in this case, he anticipated.

(Dr. Sturgis has since called my attention to the fact that Neumann (3d edit., p. 409) recognizes lupus as attacking the bones, and I find that Kaposi (Hebra. *Handbuch der spec. Path. und Therap.* III Band, II Theil, 2 Lief., p. 345), does the same, mentioning the fingers and toes, also the meta-carpal and meta-tarsal bones, producing considerable disconfigurations. Editor.)

Dr. WEISSE then presented a patient with *Lupus erythematosus* of the diffuse variety. Mr. ——, aged 45, first noticed an erythematous redness eighteen years ago, on the right cheek, which has continued to spread from that time till the present, until now the whole forehead and cheek of that side, also the neck and ear, are involved in the disease. When first seen, three or four weeks ago, there was considerable inflammation, and he was ordered the "liquor picis alkalinus" locally, with good effect. The skin of the affected portions is now red and hot, rather smooth, but scaling slightly in circles extending peripherally from the nose. The skin appears tightly drawn over the affected parts, is but moderately thickened and perhaps elevated slightly. The margins of the eruption are sharply defined. Dr. Weisse regarded the disease as the *lupus erythematoses* of the English, as described by Tilbury Fox, differing in some respects from that described by the Germans under the same name. He proposes to apply tincture of iodine to the surface, which had given him good results heretofore in this disease.

Dr. BULKLEY had a very similar case in a man, S. G., aged 41, in whom the disease had appeared four years previously, and now involved a portion of the hairy scalp, both ears and sides of neck, and on the cheeks the eruption had the characteristic butterfly appearance, caused by the union of patches by a band running across the bridge of the nose. The eruption is a little elevated, of a purplish red, with more or less scaling and with sharply defined edges. He suffers at times from a burning or stinging sensation in the diseased parts.

Dr. MITCHELL exhibited a patient, F. S., aged 33, with *Tubercular syphilis* of the nose, giving the usual history of neglect until much of the organ had become involved, bones had come away and serious deformity threatened. A large opening is seen in the

middle of the bridge of the nose and another the size of a quill in the septum at the exterior nares. The edges were thickened and the whole ulcerating surface was discharging a moderate amount of pus with very offensive and quite characteristic odor.

Dr. KEYES showed a patient with a *Cutaneous lesion following nerve injury*. A man, aged about 40, had received a crushing injury whereby the middle finger of the left hand had been lost, and shortly thereafter the present lesion had developed on the back of the hand. The papillomatous patch was of a dull-red color, irregular shape, averaging about two inches in length by one in breadth, situated longitudinally. The surface was irregularly elevated to the height, perhaps, of a line above the level of the skin, edges clearly defined, also papillomatous and not particularly everted; a little pus continually formed on the surface which was moist, and from many points pus could be made to exude by slight lateral pressure.

Dr. DRAPER stated that he had seen eczema of the hand following nerve injury. Further discussion postponed.

Dr. KEYES reported further in regard to the woman with *Scleroderma* affecting the arms and chest, exhibited at the 49th meeting of the society, October 21, 1873. The disease had ended fatally just one year from its commencement. Electrical treatment had been tried but once or twice, and with apparent temporary relief to the hardness of tissue. She died, under another physician's care, with the symptoms of severe lung trouble, although her attendant stated that there was certainly no pulmonic difficulty. The induration of the skin had gone on, rendering her quite helpless, and causing her death by exhaustion and immobility of chest walls.

Dr. KEYES then read the paper of the evening, entitled "*Chronic circumscribed inflammation of the corpora cavernosa*" (published in the New York Medical Journal, April, 1874, p. 390).

Dr. WEIR remarked, in discussion of Dr. Keyes' paper, that he had found a reference to four cases by H. E. Johnson, in the "*Lancet*" of November and December, 1859, which were almost identical with those described in the paper. In these, however, the patches were not movable, but were firm and cartilaginous, in one case more on the left than right side.

Dr. BRIDDON had seen a somewhat similar case lately. The captain of a tug boat, aged fifty, was in the enjoyment of good

nealth and had never had syphilis, nor was there any history of an injury. The tumors resembled gummy deposit in the substance of the corpus cavernosum of the right side, causing deviation on erection. The disease did *not* yield to a mixed treatment, nor to the applications of mercurial ointment or iodine. Dr. B. *thinks* that the swellings travelled backward as in Dr. Keyes' case. There were two swellings, one three-quarters of an inch long by half inch broad, within the substance of the corpus, and not in the sheath, situated three or four inches behind the corona. He had seen syphilitic gummy tumors in the same situation.

Dr. MCBRIDE related the case of a dentist, who had never had syphilis, with a hard cartilaginous mass in the right corpus cavernosum which had existed for eighteen months, causing lateral deviation on erection. General and internal treatment produced no effect; the oleate of mercury, twenty per cent. solution, caused it to diminish somewhat in size. Electricity was used, constant current, four times weekly for four months, by which means the pain almost entirely ceased and the tumor diminished considerably in size.

Dr. OTIS had met with a like case, where there was a thin plate, which seemed at first cartilaginous and afterward calcareous, occupying about two inches of space on the dorsum of penis. On close examination, calcareous deposit was found also in one of the ears. The appearances were very much like those detailed by Dr. Keyes.

Dr. VAN BUREN said that in these cases he noticed that the edges were thick and tender. The tendency to travel backward he considered unique.

(In the *New York Medical Journal*, Sept. 1874, there are given three cases supposed to be similar, by Dr. Marsh of London. Editor.)

The society adjourned to executive session.

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*Fifty-fifth Regular Meeting, March 10, 1874.*

Dr. WEISSE presented an infant, eighteen months old, with *General ichthyosis*, with the following appearances: The skin of the entire body was dry, red, thickened and scaly, and looked as

if covered with a bark, even the scalp being affected. Thick layers of epithelium could be raised and peeled off; there was, moreover, a constant exfoliation of great extent; the hair was very sparse. The thickening of the integument was very marked; it was also very stiff and hard; considerable contraction had taken place, and the whole skin seemed tightly drawn, causing also a marked ectropion of both eyes. At no time had there been any exudation, but the skin had been uniformly dry and always scaling. The child appears fairly developed, and otherwise healthy. There are no hereditary antecedents worthy of note.

In remarking upon the case, Dr. Weisse said that this condition of the skin could be very properly called *xeroderma*, which is but a grade of moderately developed ichthyosis. There are reasons, he thought, for regarding both ichthyosis and eczema as intra-uterine difficulties pertaining to the nervous system, he would speak of the tendency to these affections as an *epithelial diathesis*. Eczema, he regarded as a malformation of the epithelium, some nerve condition being present interfering with the normal development of the epidermal cells, and he considered the pathological process much the same in *xeroderma*, *ichthyosis* and *eczema*, the same tendency existing to perpetuate a perverted cell action.

Dr. PIFFARD had seen but one case of general ichthyosis, and in this there was marked increase of epidermal formation and but little redness, just the reverse of the state observed in the present case. He would rather call the case one of general eczema, and suggested the internal and external use of cod-liver-oil.

Dr. Fox suggested that the late development of eczema in so many cases would seem to indicate an accidental cause rather than an intra-uterine neurosis.

Dr. BULKLEY mentioned two instances of *general xeroderma* where the skin of nearly the whole body was very dry and harsh, scaling to considerable degree at times. One was in a girl aged thirteen, and the other in a boy of 3 years, in both of whom the disease had existed since infancy. In the girl the condition attained the characteristics of *ichthyosis* on the knees. In both the perspiratory function was almost completely arrested. The boy improved under cod-liver-oil internally and externally, it being kept continuously applied for six weeks, on one occasion. The girl mended considerably under general treatment and baths.

Dr. TAYLOR referred to LALLIER's treatment by glycerine with some stimulating substance, as oil of cade, camphor, etc., as very successful.

Dr. BRONSON introduced a patient with *Scleroderma*, with the following history:

A girl, æt. 15, with no previous or hereditary history of import, noticed a slight swelling in the back of her right hand five or six months ago; there was no pain, tenderness or change of color. Shortly after she found some stiffness in moving the fingers, and afterward the same in the arm and elbow. Meantime the arm became hard "like a board," and she was troubled in sewing. The disease was attributed to a chill from staying in the water bathing too long. The patient has the appearance of fair health, but is not robust; she has never menstruated; other functions normal. The skin of the whole right upper extremity is found to be markedly hardened, having the feeling of a cadaver. Temperature not sensibly altered. There is a faint darkening of color at the inner and back part of the fore-arm; the skin can be pinched up in parts, but without the sub-cutaneous layers, which appear bound down or solidified. In certain places, as at the wrist and at the insertion of the deltoid, the skin can be barely more than wrinkled over the subjacent structures. The points of greatest hardness are the fingers (especially ring and middle), back of hand, wrist, middle third of fore-arm posteriorly, and insertion of the deltoid. From these points the sclerosis gradually merges into tissues less dense; but nowhere below the shoulder is there a normal feeling to the parts. The same density of integument is also felt over the scapula, and below the axilla, to about the middle of the thorax. The integument over the rest of the body is quite normal; the middle and ring fingers of the affected side cannot be completely extended.

Dr. BRONSON also exhibited a patient with an unusual form of *Erythema*, associated with obscure nervous disease:

A woman, sixty-three, a year and a half previously began to suffer from an itching and burning sensation in the right thumb and fore-finger. A few months later patches of erythema began to appear on the same side, which were small, purplish, and slightly elevated, and always the seat of an aching pain, increased on pressure, as long as they lasted. The nutrition of that side seemed affected, the temperature was elevated, the nails were furrowed. The pains in the right arm and hand continued, and the erythematous patches

appeared, until the patient was attacked by a severe tonsillitis, with abscess, when there was a sudden and complete subsidence of the pain together with a disappearance of the patches, and of the swelling of the fingers. In about three weeks, however, they all returned, being confined, as before, entirely to the right side above the hips. She was subject, also, to a very severe headache and frequent attacks of angina. No special disease of any organ has been discovered, no affection of special senses, no spots of local tenderness on the cranium or spine.

Dr. BULKLEY presented for inspection a patient with *Elephantiasis Græcorum*, in the early or macular stage. (The history will be reserved for a future issue.—ED.)

Dr. WEISSE showed again his patient with *Rodent Ulcer*, at the inner angle of the right eye, first brought to the society November 4, 1873, and which had, up to that time, shown great improvement under the application of the acetate of zinc in crystals, followed by a weak ointment of the same. Since last seen, the cicatrix had broken down, and now a deep excavation existed with hardened edges. He proposed to give the zinc treatment but a short further trial, and asked the opinion of the members in regard to removal with the knife.

All present agreed as to the advisability of an operation, using a caustic after it, if necessary.

Society adjourned to Executive Session.

## Clinical Reports.

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I.—*Acute Hematuria, successfully treated by local applications.* By  
E. L. KEYES, M. D., New York.

A COLORED coachman æt. 26, naturally robust, applied to me for treatment of a gleet which had succeeded a mild urethritis due to excessive venereal excitement, and had already lasted several months. He had had no systematic professional advice, but had been dosed continuously by a druggist with varying nauseous compounds, until when I saw him he was restless, depressed, with pallid lips, no appetite, and complaining of incessant crampy pains in the back and belly, a little frequency of urination and a continuance of the gleet.

I stopped all medicines and ordered a tonic with iron. Before taking this he was suddenly seized with hematuria, the attack preceded by vesical irritability. At first the blood flowed only after exercise, the urine being clear in the morning. The blood was always red, never black. Sometimes there were clots, but these when passed, *always* appeared during the early part of the flow. Urination was only slightly painful. The amount of blood lost was considerable, the urine smelling and looking like pure blood, the mass being entirely opaque and very thick. The patient was advised rest, cessation from work, avoidance of sexual excitement, and received in succession different styptic and astringent drugs internally, as well as by injection into the bladder; this over a period of several weeks. His condition, however, became constantly aggravated until he passed blood incessantly, as much in the morning as at night, and although his appetite was fair and his pain inconsiderable, he showed daily increasing signs of advancing anæmia. The microscopic examination of the urine

yielded only negative results; rectal examination was also negative. Finding that general means were useless, I determined, if possible, to make out the exact seat of the hemorrhage and then decide upon a course of action. A large steel sound passed readily into the bladder—not occasioning any excess of pain. On withdrawing it, only a trace of blood could be squeezed from the urethra, none oozed out subsequently, but the urine next passed was, if possible, more bloody than before. This located the seat of the hemorrhage behind the cut off muscle of the membranous urethra.

Next a soft catheter was passed into the bladder, attached to a fountain syringe with a two-way stop-cock. The bladder was alternately filled with and emptied of warm water, until the latter flowed clear. Now the bladder was left empty without moving the catheter, and the urine which collected when drawn off, was faintly tinged. Again the bladder was washed and the water flowed clear. Hence the blood did not come from the bladder walls.

The bladder, already washed, was now filled with water, the catheter gently withdrawn, and the patient made to pass the injected fluid. It flowed out in a stream of brilliant crimson resembling pure blood. After repeating these experiments carefully, assisted by Dr. L. A. Stimson, I located the seat of the hemorrhage in the prostatic sinus.

From previous success in a case\* where the blood flowed from a somewhat similar situation, I determined to cauterize the prostatic sinus with solid nitrate of silver, using Lallemand's *porte caustique*. A light application was made with an instrument badly prepared, and it seemed rather to aggravate the symptoms. Having freshly loaded the instrument, I made a thorough application two days afterward. The patient continued to pass blood for about twenty-four hours, when it ceased. Symptoms of cystitis of the neck came on, which gradually but spontaneously disap-

\* VAN BUREN AND KEYES, Genito-urinary diseases with syphilis. New York, 1874, p. 139.

peared, and the patient did not again pass blood with his urine. It will be interesting to ascertain whether there has been an occlusion of the mouths of the ejaculatory ducts—a risk which was knowingly assumed.

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## II.—*Case of Herpes Zoster Frontalis, successfully treated by Electricity.* By Dr. BULKLEY.

The following case is given as a contribution to the natural history of this peculiar disease, and its successful treatment :

Mrs. G. G—, aged thirty-six, a lady of delicate organization, generally enjoying good health, with the exception of constipation, not subject to neuralgia, was first seen by me May 29, 1874. Five days previously she had noticed some small groups of papules forming over the right eye, which soon increased in size and developed into clusters of vesicles, some of which coalesced and formed quite large bullæ. The same developed also upon the hairy scalp of the same side, nearly to the occiput, and shortly a small cluster of vesicles developed on the cheek, and later on the upper lip of the same side.

Three days after the first appearance of the papules she began to experience pain over the right eye, running backward, and some pain beneath the eye. The pain increased very rapidly, soon becoming intense and pretty constant, with occasional sharp accessions, causing her to cry out. Sleep had been entirely prevented. About the time the pain was first felt the right eyelids began to swell, and soon the left also, from sympathy.

When first seen the patient was very nervous and excited from the intense pain, which large amounts of opium, chloral, etc., internally, had failed to control. Pulse 108, temperature in axilla 100°, tongue pale, indented and coated. Almost the whole of the right forehead was found to be covered with groups of vesicles and bullæ of irregular shape, caused by their confluence. Some of these were already drying, others just forming. There was nothing unusual in their appearance. Numerous clusters of the same could be felt and seen among the hair, also on the upper eyelid and in the brow; likewise on upper lip of same side. The right eye was closed by œdema of the lid. On forcing it open the cornea was found to be intact. The left eye could be used, but was partially closed by œdema. She complained bitterly of pain, and begged for

relief. She was ordered five grains of the citrate of iron and quinine every three or four hours, and advised to have electricity applied at once.

May 30. Electricity was applied by my friend, Dr. George M. Beard, last evening at about seven o'clock. A continuous galvanic current from eight cells was employed, the negative pole being placed indifferently on the back of the head, neck and epigastrium, and the positive passed with a moist electrode over the eruption and pressed upon the eye. The relief obtained was prompt, occurring in about three hours, so that she slept comfortably, the first for several nights, and has had no very acute pain since the first application.

June 8. The electricity has been applied daily until three days since, gradually increasing in strength, until sixteen cells are used to-day, with a view to hasten the exsiccation, diminish the amount of scarring, and relieve the slight but dull aching pain remaining. She is up and around, feeling fairly well. The swelling of the eyes is all gone, it subsiding rapidly on the application of electricity. She continues her iron and quinine, and is to have central galvanization applied for a little time longer to promote healing and as a tonic. Many of the crusts have already fallen.

The prompt checking of the developing eruption under electricity, with the arrest of pain, together with the fact that the eye was left uninjured, notwithstanding the œdema of the lids and the appearance of vesicles on their outer surface, form the interesting and practical features in this case.

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### III.—*Chronic Eczema of Legs and Arms—Sixteen Months' Standing—Great Itching—Rapid Relief and Cure Under Central Galvanization alone.* By GEORGE M. BEARD, M. D.

Mr. S., aged forty-five, of a strong constitution, had suffered for sixteen months from chronic eczema of both legs below the knees. At one stage the eruption extended over the face and body, and when he consulted me there was a slight appearance of the disease on the arms. The itching and burning were very severe, and kept him awake at night. The patient had also asthma.

On examination, I found a tender spot on the lower lumbar vertebræ, such as is often found a little higher up in spinal irrita-

tion. At this point he sometimes had pain. There was no other special evidence of disease of the nerve-centres. The patient was considerably debilitated by long suffering and deficiency of sleep, various ointments having been tried by different physicians with no relief. When first seen his legs were covered with bandages saturated with ointment. I ordered him to remove these, and to stop all treatment, and I at once began the use of central galvanization, *making no application whatever to the diseased surface*. The night after the first application he slept well, as also the succeeding night, on account of the relief of the itching and burning pain. After three applications, there was, in addition, a very clearly defined improvement in the appearance of the legs.

The treatment was now interrupted for a time by severe asthmatic attacks, but for two weeks there was no itching nor pain. On resuming treatment by central galvanization, the patient represented that he was not only relieved, but that his general health was improved. The pain in the back had disappeared, and there was no tenderness.

At this stage of the disease, when the patient was not yet entirely free from its indications, and the eczema was distinctly visible on the legs, I sent him to my friend, Dr. L. D. Bulkley, for examination. In about four months, and after less than twenty applications, the recovery was complete.

The above case is of special interest as confirming the results of treatment by central galvanization in a similar case treated two years ago. This case was reported in *The New York Medical Record*, August 15, 1873, and was, like the present, treated by central galvanization alone, no application of electricity or any other agent being made to the diseased surface.

(Through the kindness of Dr. Beard, I have a letter from Dr. D. N. Kinsman of Columbus, Ohio, with the account of a case of *eczema treated by electricity*, which is of interest in this connection :

“A vigorous man, sixty-eight, for twenty years had an eczema, on the back, commencing at the upper border of both scapulæ and extending to one inch below their inferior angles, with the central portion of the back free; also on the fore-arms. The skin was thickened and the itching intolerable. He had had rheumatism.

“The constant current from sixteen cells was used almost daily, the negative pole being applied to the epigastrium and the positive to the back of the neck along the spine, in temporo-maxillary fossæ

and over the eruption. The moment the current is passed along the spine the pruritus ceases. The eruption, after about a month's treatment, has improved, the thickening has disappeared, and for the last ten days there has been no itching. That on the arm remains and still itches. Coffee, chocolate and other articles which formerly aggravated the disease, have been indulged in with impunity since the treatment."

The case is still under treatment, and we hope to hear further from it.—ED.)

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IV.—*Clinical Records of Syphilitic Affections of the Eye.* By FRED. R. STURGIS, M. D.

I submit the two following cases of diseases of the eye due to specific causes, as they serve to illustrate some points in the clinical features of the disease which are not devoid of interest:

I. *Syphilitic Iritis and Neuritis.*—A. R., 27 *æt.*, presented himself at the hospital with an iritis of the R. E.\*

He gives the following history: In 1871 he contracted the primary lesion, followed a few weeks after by mucous patches of the mouth and throat. In 1872 he was under my care at the hospital for a specific iritis of the same eye which recovered under mercurials. He also presented some mucous patches of the tongue and throat.

He has had no further trouble until Monday, March 23, 1874, when his R. E. was attacked as follows:

The conjunctival vessels as well as those of the sclerotic were intensely congested; the iris dull and sluggish. The pupil did not respond to light. Supra-orbital pain, photophobia and lachrymation were very slightly marked. There was no photopsia. On testing him with Galezowski's chromatic scale, appreciation of colors was good. There was no cyclitis, but there was a triangle of a dull ground glass appearance seated in Descemet's membrane. V. L. E. = 1. R. E. =  $\frac{2}{7}$ .

He was put upon the mixed treatment in the following form: Rx—Ung. Hydrarg. 3 i, to be rubbed on the soles of the feet each

\* In explanation of the abbreviations allow me to say, that V. stands for vision; R. E., for right eye; L. E., for left eye; I., means normal vision, *i. e.*, reading No. 20 Snellen's scale at 20 feet; the sign ' stands for feet.

night. Rx—Tr. Iodine (U. S. P.), 3 ii. Syr. Aurant. Cort.  $\frac{3}{2}$  iii.—M Sig., one teaspoonful, thrice daily. Rx—Atrop. Sulph. Sol. (gr. ii-aq. dist.  $\frac{3}{2}$  i.) gtt. i., to be instilled into the eye every four hours.

*March 28.*—The pupil was fully dilated and no adhesions were found to exist. The keratitis had entirely gone, but singularly enough the photophobia and lachrymation had increased. The atropine was used every hour, the mercurial continued and the iodine increased to 3 ii. at a dose, and he was instructed to wear coquilles. On the 31st, the record was made that the photophobia and lachrymation had gone. As there was some mercurial fetor the ointment was discontinued. *V. R. E.* had improved to  $\frac{2}{5}$ .

*April 4.*—Vision still as on March 31st. The eye had improved enough to bear an ophthalmoscopic examination, when it was found that the optic disc of R. E. was blurred in outline, and had a woolly look—vessels starting from the nerve entrance were indistinct—no changes in the retina or choroid.

He was directed to use the mercurial ointment to the brow every night, and to take one-half gr. pill of Hydrarg. Protiod. three times daily, omitting the iodine mixture.

He continued this treatment, omitting and renewing it as occasion required, until the middle of May, when it was discontinued. All trace of trouble had disappeared. *V. R. E.* = 1. *L. E.* = 1. The ophthalmoscope showed a normal fundus.

The points most noteworthy in the case are the slight amount of subjective symptoms compared with the apparent severity of the objective ones, the participation of the cornea in the attack, common enough in the congenital form of the disease, rarer in the acquired, and the concomitant neuritis. It should be observed that the ciliary body, the choroid and the retina escaped.

*II. Specific Iritis, R. E., conjoined with Neuritis.*—W. W. came under observation April 2, 1874, with an iritis of the R. eye of ten days' duration, in which photophobia and congestion of the sclerotic and conjunctival vessels were well marked. There was also an extensive syncœchia of the pupil. There had been no cyclitis, no supra-orbital pain nor hemi-crana. Reports his eyesight has been gradually giving out, and at the time of his admission can only distinguish light from darkness.

His primary lesion was contracted in January, 1874, which was followed by roseola. He was at once put upon the Protiodide of mercury in one-half grain doses twice daily.

On the 4th it is recorded that he could count fingers at 2' dis-

tance. Photophobia and congestion less. The adhesions were so strong as to be unaffected by the use of atropine. Reports the eye as feeling stronger. V. L. E. = 1. R. E. =  $\frac{2}{3}$ . The dose of Protiodide was increased to three pills daily, and this was again reduced on the 7th to two daily, with the addition of inunction of 3 ss Ung. Hydrarg. over the brow at night.

On the 14th, the iritis had disappeared, although there was still some photophobia. V. R. E. increased to one-half. As the gums and teeth were a little tender, the mercurial was suspended, to be resumed three days later in the dose of one pill, and the same amount of the ointment as on the 7th inst. On the 21st inst., the vision was two-thirds, and for the first time the ophthalmoscope was used, showing hyperæmia and swelling of the nerve entrance, an indistinct, veiled outline and tremendous venous congestion. On the 25th inst., V. = —1, but the ophthalmoscopic appearances had not materially changed since the 21st. The 28th showed the same amount of vision, and the fundus looked better. The disc was clearer and of a pinker hue; the venous congestion had abated. A curious phenomenon was now observed. One of the ascending retinal veins, a short distance from the porus, looked as though it were plugged with a clot. There was, however, no pulsation in that portion of the vein near the disc. This was, on the 5th, decided by Dr. Roosa (who saw the case at my request) to be an optical delusion, due to the vein dipping down over the swollen disc into the porus. From these prolonged examinations V. had diminished, first to two-thirds, then to one-half. The iodide of potassium, gradually increased from 20 to 50 grs. thrice daily, was then used, combined with the pills, sometimes with and sometimes without the ointment, until the 2d June, when the following record was made :

V. both eyes = 1. The appearance of the vessel spoken of in the record of May 2d was less marked. Venous congestion gone. Fundus normal, except that the disc was a little wooley. This gradually cleared up.

**Remarks.**—In both these cases the result was better than we often get. Vision does not always return to the normal standard, but what I wish to call attention to is the fact that the greatest benefit was obtained where mercury is pushed to its fullest physiological effect, more so than where the iodide or iodine is used alone. I have the record of other cases where this is better shown even than it is in these, and which I hope shortly to publish.

One other point is noteworthy, viz.: the comparatively short time after the primary lesion that the neuritis occurred; in this case only three months. A syphilitic neuritis is usually regarded as a tertiary lesion; so it may be; besides this, it may be an early secondary one and where it is, the chances of recovery are infinitely better than when the lesion occurs in the later stages. Indeed, I may say that there are no lesions of the deep tissues of the eye, which we heretofore have been accustomed to regard as tertiary, but may occur in the early stages, that is a few months after infection. With this important difference, however, that in the latter, recovery is more certain, the lesions are probably more superficial and less liable to be followed by degenerative changes in the tissues.

## Extracts and Translations.

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### HISTOLOGY OF THE TACTILE CORPUSCLES AND RETE MALPIGHI.

ABSTRACT FROM THE GERMAN OF DR. PAUL LANGERHANS.\*  
By ARTHUR VAN HARLINGEN, M. D.

#### TACTILE CORPUSCLES.

PARTIONS of very recently removed skin soaked in one-half per cent solution of osmic acid for twenty-four hours show, on microscopic examination, a black coloration of the few remaining oil globules, and also of the medullated nerve fibres. Elsewhere only a yellow tinge prevails, which, after the specimens have lain for some days in alcohol or glycerine, changes to a dark brownish shade. The *rete* and sweat glands are colored light yellowish-brown, the horny layer showing a variety of colors, to which allusion will subsequently be made.

If a properly stained preparation containing a tactile corpuscle be now examined, the following appearances will be observed: Not only are the afferent nerve fibres stained black, and therefore rendered quite conspicuous throughout that section of their course which lies within the corpuscles, but in addition a considerable proportion of the transversely striated structures of the latter have assumed a black color. These structures pursue in part a winding course on the outside of the main body of the corpuscle often in direct connection with the afferent nerve so as to form, as it were, a portion of the latter, and in part lose themselves within in twisted filaments.

Near these long and relatively narrow filaments are found numbers of club, or knot-shaped masses which resemble nuclei, excepting that they are tinged deep black, a color not assumed by the

\* Max Schultze's *Archiv.*, 1873, p. 730.

latter under the action of osmic acid. A closer inspection shows that many of these club-shaped bodies are smaller than nuclei are apt to be, and that they frequently terminate on one side or the other in longer or shorter filaments which wind around the periphery of the corpuscle or run toward the centre and are lost. If a number of preparations are examined, occasionally some of these club-shaped bodies will be found to possess, by means of their filamentous continuations, direct connection with well recognized nerve filaments. That these bodies are true terminal nerve bulbs is proved not only by tracing their course, as above, but by consideration of their color. But four elements in the human body assume a black tint when exposed to osmic acid under the circumstances mentioned, namely, part of the horny layer, the outer section of the retinal rods, fat, and myelin. It is evident that the first three of these must be excluded here; we have therefore myelin in these tactile corpuscles which is colored black. Although the osmic acid process facilitates greatly any attempts which may be made to follow the course of the nerves in the tactile body, yet it is very difficult to get an exact picture of their course as a whole. The thickness of the corpuscle, the great number of the collected nerve terminations, and the complicated course of the nerve fibres necessarily resulting therefrom, must naturally render any successful tracing out of an individual fibre to its terminal bulb a very difficult task. Nevertheless the connection between the fibres and the terminal bulbs may be inferred with great probability, indeed, almost with certainty.

In addition to these nerve fibres there may also be observed in the tactile corpuscle certain cells containing large nuclei. If a very delicate section of a corpuscle, treated with osmic acid, be examined carefully, certain large, clear nuclei will be observed between the blackened nerve fibres, surrounded, especially in longitudinal sections, by a small quantity of cell substance. I have not been successful in coloring these nuclei with carmine in the presence of osmic acid, although by allowing the preparation to remain for twenty-six hours in a one-per-cent picro-carmine solution, or in Gerlach's solution, the nuclei assume a light sepia tint, which renders their investigation easier. Hæmatoxylin forms a much better staining material, and is preferable to carmine.

The nuclei thus stained appear decidedly larger than the sec-

tions of terminal nerve bulbs, and resemble closely other nuclei visible in the preparation, particularly those of the connective tissue. They are surrounded by a small quantity of cell substance, which demonstrates the nucleus as the centre of a true cell, and there genuine cells are seen throughout the tactile corpuscle between the nerve filaments, separated from each other, and grouped, as it were, among the latter. The tactile corpuscle may, in fact, be regarded as made up of a great number of single cells which are characterized by the delicacy and small amount of their cell substance, while the nervous elements are distributed among them in all parts of the organ. The peripheral cells are everywhere in contact with the surrounding connective tissue, and the corpuscle cannot, therefore, be regarded as surrounded by any distinct limiting membrane. The number of single cells which constitute the entire tactile body as well as the size of the nervous elements render sections of this organ in the adult so complicated in their appearance as to be comprehended with difficulty. The relationship of the various elements may be better understood by examining sections from the skin of very young infants. As to the nature of these cells, it is difficult to speak positively, but their appearance would certainly point to their connection with those of the connective tissue.

As regards the termination of the nerve sheaths investigation has thus far failed to prove their continuance to the very end of the terminal bulbs, though this seems highly probable.

#### RETE MALPIGHI.

Allusion has been made above to the fact that after staining with osmic acid the rete malpighi assumes a uniform brown tint, while various colorations are observed in the *stratum corneum*. The latter, if sufficient osmic acid be used, assumes a decided black color, nearly down to the *rete*, a narrow layer, generally about two cells thick, remaining between the two, which takes on a uniform yellow color, throwing the nuclei, which remain clear, into bold relief. The cells of this layer, called by Oehl and Schön the *stratum lucidum* of the *rete*, present invariably certain peculiar striations parallel to the long axis of the *papillæ*, and consequently perpendicular to the largest section of the cells themselves.

It might seem a matter of indifference whether this *stratum*

*lucidum* be considered as connected with the *rete* or with the *stratum corneum*. The action of various reagents, however, demonstrates a sharp line of demarcation between the former and the *rete*, while its connection with the horny layer is much closer, and it should therefore be considered as belonging to the latter.

The true *rete* itself seems to be divided into two distinct strata, the upper of which consists of cells having general granular contents while the lower is composed of the well known prickle-cells (*riff-zellen*). The appearances brought out by the use of picro-carmine in sections of recent skin which has been frozen and cut, show these various relations to a very marked degree. The cells of the *stratum lucidum* take on a transparent color which gradually fades away above. The elements composing the upper section of the *rete* show intense colorations of their granular contents, which appears to great advantage in the neighborhood of the openings of the perspiratory ducts. Below, the nuclei of the lower section of the *rete* present a deep carmine color, while the cells themselves are but slightly tinted.

The intense coloration of the upper granular cells of the *rete* show them to be younger elements, and the stratified appearances presented in these sections go toward proving the inaccuracy of the generally received theory of gradual metamorphosis on the part of the elements composing the *rete* into the epithelium of the *stratum corneum*. The already well known position of the pigment layer in the colored races speaks against a sharing by the lower cell layers of the *rete* in the physiological regeneration of the epidermis. On the other hand it would appear from these investigations as if the real germinal layer (*mutterboden*) of the *stratum corneum* is to be looked for in the upper strata alone of the *rete*.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### ANATOMY, PHYSIOLOGY AND PATHOLOGY.

T. E. SATTERTHWAITE, M. D.

1. **Bernhardt, M.** — The sensibility of the skin (*Die Sensibilitäts Verhältnisse der Haut*), Berlin, 1874, p. 25.
2. **Friedlander, Carl.** — Investigations on Lupus (*Untersuchung über Lupus*), Virch. Archiv. LX. 1, 1874.
3. **Juler, H. Cundell.** — Cheloid having the appearance of molluscum. British Med. Jour., April 18, 1874.
4. **Lukomski.** — Researches on Erysipelas (*Untersuchungen über Erysipel.*), Virch. Archiv. LX. 111, 1874.
5. **Mitchell, S. Weir.** — Supply of nerves to the skin. Phil. Med. Times, 126, 1874.

FRIEDLANDER (2) has examined twelve cases of *lupus vulgaris*, and has given a detailed account of the microscopical appearances. Eight were classed as *Lupus exulcerans*, two as *Lupus exfoliativus*, one as *Lupus hypertrophicus*, and two had no special classification. None of them belonged to the seborrhœic type. They were all found to have nearly the same general character, differing only in the degree of their development. The epidermis was never involved by the diseased process, which was strictly confined to the corium or subjacent tissues. The characteristic lupus-tissue seemed to consist of globular masses or tubercles, having a diameter of from  $\frac{15}{100}$  to  $\frac{4}{10}$  of a millimetre. These tubercles were distinguished from the ordinary granulation tissue by being colored yellow by picric acid, while the granulation tissue was colored bright red by an ammoniacal solution of carmine. In almost every case the tubercles extended to the epidermis. In the exfoliative form the lupus tubercles far exceeded the granulation tissue in amount, but in the ulcerating variety they were single, or, if in groups, so surrounded by granulation tissue

that they could hardly be recognized. The form of the cells was usually cuboid, less often globular or elliptical; the contours were usually uneven, though the author expressly says they were not serrated. The protoplasm of the cells was sometimes finely and sometimes coarsely granular; an intercellular substance was generally seen. These cells were hardly colored at all by acid or alkaline solutions of carmine. The nucleus or nuclei were usually round and had a sharp contour; they always contained several nucleoli, and were very slightly colored by carmine. They did not differ essentially in size from the nuclei of the granulation tissue, but were not nearly so bright. The cells themselves were much larger than granulation cells. They averaged, perhaps,  $\frac{12}{1000}$  of a millimetre in diameter, while the granulation cells were about one-third the size. Frequently larger cells were met with, and they were identical with the typical giant cells. The nuclei of these cells were oval and very numerous, sometimes reaching a hundred, and were arranged near the periphery. The diameter of these cells averaged, perhaps,  $\frac{7}{100}$  of a millimetre, but they often were very much larger. The author combats the recent views of Hering that giant cells, referring especially to such as occur in tuberculosis, are not really cells, but the contents of lymphatic vessels that have become coagulated during the process of hardening the specimen; and that the bodies occurring in them are really endothelial elements which have been changed by the process of growth. His reasons for sustaining the old view are, (1) that the giant cells are rounded in form, like cells, and (2) that he has observed in them certain slow but unmistakable amoeboid movements, and (3) that a gradual transition can be traced from the smaller cells first described to these latter. In some instances there was a good deal of granular matter containing indistinct nuclei with oil globules about the cells. Possibly these were remains of older formations, and were now becoming altered by the process of retrogressive metamorphosis. The author never observed any such completed change. The following distinctive differences were given between the tissue of lupus and the rete malpighi: The cells of lupus (1) are not prickle-cells, they (2) do not lie in close apposition, they (3) are not so dense or coarsely granular, and (4) there is a marked difference between the nuclei. In those rare cases where the lymphatic glands are involved the

change did not merely consist in a hyperplastic growth of the gland tissue, but there was an actual infiltration with tuberculous masses that had the same minute appearances as lupus tubercles elsewhere.

JULER (3) describes the case of a negro on whose skin pendulous masses had been growing for thirty years. The first appearance of the disease dated, according to the patient, from a cicatrix following an abscess in front of the lobule of the ear. The growths were of various sizes, some as small as a coriander seed, and others several inches in diameter. Usually they did not give him special annoyance, but occasionally he was in great distress from the darting pains that passed through them. The disease itself, as admitted by the author, did not exhibit the characteristic signs of cheloid that are laid down by writers, but he believed there were good reasons for designating the disease cheloid rather than molluscum fibrosum, and he discusses them at some length. A microscopical drawing accompanies the article, and some space is given to a description of the pathological appearances, though we confess ourselves unable to observe the changes he refers to. The drawing itself is utterly unsatisfactory and can serve no useful purpose in a scientific point of view.

During the spring of 1873, Recklinghausen examined several cases of *erysipelas* to discover whether the diseased tissues contained any minute organisms which were peculiar to this affection. After negative results in several advanced cases he found in two very recent and rapid ones that the lymphatics and serous canaliculi of the skin on the borders of the erysipelatous tissues were filled with the micrococcus. The results of LUKOMSKI's inquiry (4) in nine instances confirmed these two points, excepting that in two cases where the disease was advanced, having lasted several days, the micrococcus was found in the subcutaneous tissues. A series of sixteen experiments was then made on animals to determine whether erysipelas could not be artificially induced by contamination with material containing minute organisms. In the first six of these cases he injected the fluid hypodermically. His conclusions were that erysipelas can be produced in this way, when, too, decomposing substances are carefully excluded. The difference in the form of the two processes was that in typical erysipelas the cutis is principally affected while in his experiments it was the subcutaneous tissues. In the last ten experiments the

infecting material was laid upon the open wounds, and the inflammatory process that ensued was not distinguishable from erysipelas. He observes that the micrococcus and bacteriæ pass into the tissues through the serous canaliculi and lymphatics. The disease subsequently extends in certain definite directions which the author describes at some length.

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### THE EXANTHEMATA.

FRANK P. FOSTER, M. D.

1. **Cowie, R.** — Primary vaccination during period of incubation of small-pox; confinement during attack of that disease; recovery. *Brit. Med. Jour.*, Jan. 17th, 1874, p. 79.
2. **Fitzmaurice, R.** — Remarks on small-pox. *Dublin Jour. of Med. Science*, Jan., 1874, p. 13.
3. **Gamberini, P.** — Variola and Varicella, their relations (*Il vaiolo e la varicella, loro attinenze*). *Giorn. Ital. delle Malattie Veneree e della Pelle*, April, 1874, p. 65.
4. **Kelly, D.** — Report on small-pox in 1871, 1872 and 1873, at the Workhouse Hospital, Mullingar; with some remarks on treatment. *Dublin Jour. of Med. Science*, Jan., 1874, p. 7.
5. **Kramer, E.** — Two interesting cases of variola (*Zwei interessante Fälle von Variola*). *Vierteljahrsschrift für Dermatologie und Syphilis*, I Jahrg., 1 Heft, p. 41.
6. **Luther, M.** — On small-pox and vaccination; experiences in the Franco-Prussian war. *Med. and Surg. Reporter*, March 28th, 1874, p. 280.
7. **Müller, A.** — A contribution to small-pox statistics and to the vaccination question (*Ein Beitrag zur Pockenstatistik und zur Impffrage*). *Archiv der Heilkunde*, XV Jahrg., 2 Heft, p. 178.
8. **Senator, H.** — The connection between Varicella and Variola (*Ueber das Verhältniss der Varicella zur Variola*). *Jahrbuch für Kinderheilkunde*, n. f., VII Jahrg., 4 Heft, p. 444.
9. **Steele, A. B.** — Insusceptibility to vaccination. *Brit. Med. Jour.*, Jan. 10th, 1874, p. 47.
10. **Von Mansfelde, A.** — The treatment of small-pox. *Med. and Surg. Reporter*, Jan. 10th, 1874, p. 27.

Of 117 cases of small-pox, treated by FITZMAURICE (2) during the six months ending April 30th, 1873, 44 were in vaccinated, and 73 in unvaccinated persons. Of the former, three died (about seven per cent.), of the latter, 34 (a little under 50 per cent.). Not a single case occurred after revaccination. No benefit seemed to follow the antiseptic treatment. Reliance was placed on chlorate of potassa in large doses, with leeches to the temples in cases of delirium.

GAMBERINI (3) gives an historical and critical review of the facts bearing upon the question of the identity of small-pox and varicella. The author concludes that there is a simple, non-variolous varicella, but also that there is a form of varicella which seems to be the mildest variety of varioliform disease.

KELLY (4) reports that *purpura and menorrhagia occurring with small-pox* were most effectually controlled by the sulpho-chloride of iron. Two to four grains of tartar emetic, with 40 mimims of acetum opii, at one dose, were found to succeed well in calming delirium, otherwise the treatment included nothing noteworthy.

The first of KRAMER'S cases (5) was one of varioloid complicated with scarlet fever, which broke out on the eighth day. The patient was 17 years old, which is of interest in connection with the fact that the concurrence of two different exanthems is most generally met with in children. The second case was also one of varioloid, in which a fresh crop of pocks broke out on the twentieth day, with renewal of the eruptive fever four days previously. Similar cases of a second attack of small-pox after a very short interval are referred to as reported by Richter and Spezer.

MÜLLER'S article (7) deals with the epidemic of small-pox which prevailed at Waldheim from January, 1872, to April, 1873. In a population of 5,200 souls 4,713 had been vaccinated or had previously had small-pox, and 342 had not been successfully vaccinated. Of the former, 124 (2.6 per cent.) took small-pox, of the latter, 126 (36.8 per cent.); 11 of the vaccinated and 55 of the non-vaccinated died. The casuistics and mortality are also shown in their relation to age, social condition, sanitary surroundings, etc.

Arguments are brought forward by SENATOR (8) and cases related to show that *varicella and small-pox* depend upon distinct

causes, that neither one of them protects the system against the other, and that the former is so particularly a disease to which children are prone that it occurs most often in them notwithstanding recent vaccination, whereas even non-revaccinated adults generally resist it—the very reverse of what we should expect to find were varicella a disease of variolous origin.

In more than 10,000 vaccinations STEELE (9) has met with only two instances in which there was failure after three trials in consecutive weeks.

VON MANSFELDE (10) recommends vaccination in the *treatment* of small-pox, and speculates as to its *modus operandi*.

11. **Besmir, E.**—Miliaria (*De la Miliarie*). *Annales de Dermatologie et de Syphiligraphie*, Tome V. 1, p. 24.

12. **Steiner.**—Morbilli bullosi sive pemphigoidei. *Jahrbuch für Kinderheilkunde*, n. f., VII Jahrg., 3 Heft, p. 346.

STEINER (12) contributes four cases of this exceedingly rare form of measles, *morbilli bullosi*, being the only ones that he has met with in nearly 6,000 cases of measles. The morbillous eruption was complicated with the simultaneous formation of blebs of various sizes on the skin and the oral and nasal mucous membranes. One of the four cases proved fatal by acute hydrocephalus. The question is raised whether the disease is truly a pemphigoid variety of measles, or measles complicated with pemphigus. The blebs appeared in successive crops, contrary to what happens in cases of scarlet fever complicated with a pemphigoid eruption.

13. **Mayer, G.**—On the treatment of Scarlatina and Diphtheria (*Bemerkungen zur Behandlung von Diphtheritis und Scarlatina*). *Jahrbuch für Kinderheilkunde*, n. f., VII Jahrg., 4 Heft., p. 433.

In the period comprised between the summer of 1873 and the month of May, 1874, the author (13) treated 49 cases of *scarlet fever*. The epidemic was comparatively mild, and the cases were few in which serious sequelæ remained. Cold baths (from 27° to 21°, R., [93° to 80° Fahr.,] and in cases of very great fever, 18° R., [72°,5 Fahr.]) were used in all but eight cases, and generally proved very beneficial. In cases of persistent high fever, they were supplemented with large evening doses of quinine. Inunction seemed to soothe the irritation of the skin, but its refrigerant

action was not manifest. The fulminant cases were found to be of two classes: (1) those in which coma was directly dependent upon hyperpyrexia, and which were evidently benefited by the cold baths; and (2) those in which the direct paralyzing influence of the scarlet fever poison on the brain was the root of the trouble, and in which the use of cold baths had to be conducted with more moderation, while at the same time stimulation was effected by the subcutaneous use of camphor, wine, etc.

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## INFLAMMATIONS; PSORIASIS, LICHEN, IMPETIGO, ETC.

GEO. HENRY FOX, M. D.

1. Clarke, W. Fairlie.—Psoriasis of the tongue. Practitioner, Aug., 1874.
2. Clarke, W. Fairlie.—Ichthyosis linguæ. Brit. Med. Jour., March 14 and 28, 1874.
3. Debove.—Buccal Psoriasis (*Le psoriasis buccal*). Paris, 1873.
4. Fox, Tilbury.—So called Ichthyosis linguæ. Brit. Med. Jour., March 21, 1874.
5. Morris.—Ichthyosis linguæ, followed by Epithelioma linguæ. Brit. Med. Jour., Feb. 21, and March 14, 1874.
6. Duckworth, Dyce.—Clinical Notes on the Diagnosis and treatment of Psoriasis. Lancet, July 4, 1874.
7. Duhring, L. A.—Differential Diagnosis between Psoriasis, and Syphiloderma squamosum. Phila. Med. Times, Feb. 7, 1874.
8. Gaskoin.—On the relation of Asthma to Skin diseases. Royal Med. and Chir. Soc. Lancet, March 28, 1874.
9. Simon, Oscar.—Cases of Impetigo Contagiosa. Berlin Klin. Woch., Feb. 23, 1873.

The term "*Psoriasis of the tongue*," according to CLARKE (1), should not be applied to every thing amiss with the lingual or buccal mucosa. Especially should it not be applied to that condition of the tongue to which Ullmann applied the name *tylosis linguæ*, as is frequently done by French writers, e. g., by Debove in his recent article on "*Psoriasis buccal*." Hard, raised, corny or warty, white patches, are a leading feature of *tylosis*. Upon

their removal, which often requires considerable force, the subjacent tissues are found red and raw, and never return to their natural condition. The tendency to become cancerous is marked, and epithelioma will surely be developed if the patient lives long enough. Now, psoriasis of the skin is a disease of the cuticle attended by enlargement of the papillæ in aggravated cases. It never goes deeper. It is often readily cured and never becomes malignant. An analogy between the two diseases is wanting. In England, since attention was drawn to it by Mr. Hulke, in 1864, the disease has gone by the name of *Ichthyosis linguae*, an equally unfortunate misnomer, for ichthyosis of the skin is associated with sebaceous and perspiratory derangement, essentials in the pathology of the disease; hence Ichthyosis of the tongue is an impossible condition. In many other respects the diseases differ. Tylosis (from the Greek  $\tau\upsilon\lambda\sigma$ , a callosity) is the best name yet suggested for the disease, and the mischievous habit of transferring names of diseases of one tissue to those of another is to be regretted.

Our author, however, refers to a disease of the tongue, which, with more propriety, might be called Psoriasis, and to which this term, if used at all, should be restricted. A patch of the mucosa becomes whitish, opalescent and slightly thickened, appearing as if it had been lightly penciled with nitrate of silver. It passes away in a short time, leaving no trace, but is apt to return. This disease is rare, seen chiefly in middle aged persons, and is usually, if not always, associated with Syphilis.

DEBOVE (3) gives a record of twenty-four cases of *buccal psoriasis*, a bibliography and two plates. The affection is defined as chronic, seated generally on the dorsum of the tongue, and internal aspect of cheeks and lips, and characterized by a whitish, mamillated appearance of the mucous membrane, which is often fissured and indurated. As Bazin has stated, the disease is not painful but very obstinate, and most often observed in arthritic subjects. The cheeks and lips are its favorite seat, though here being less troublesome than on the tongue it is apt to remain unseen by the physician, if not even unknown to the patient. D. speaks of cancer of the tongue as *frequent* termination, though not following in all cases. Pathologically there is found a thickening of the epithelium and a thickening and a *sclerosis* of the chorion, differing in this respect from psoriasis cutis. Women are rarely

affected; perhaps from the fact of their seldom smoking, although it occurs in males who never smoke. It frequently appears in syphilitics and often follows syphilitic lesions of the tongue. Still the local nature of the disease is not to be denied, and in these cases the syphilis has simply acted as a local agent awakening the disease. In this manner syphilitic patches on the palms often occasion in dexterous subjects a palmar psoriasis, not amenable to specific treatment. Tobacco, however, rather than syphilis, and a short pipe in particular, is, in a large number of cases, the exciting cause.

Fox (4) objects to the term *Ichthyosis linguæ* since the disease lacks any similarity in its parts to those functional derangements of the skin which are essential elements in ichthyosis of the skin. He considers also the general definition of ichthyosis of the skin as too limited. He recognizes in the so-called ichthyosis linguæ a relationship to warty growths; regards it as an early stage of epithelioma, and would substitute for this name either tylosis or keratosis linguæ.

MORRIS (5) gives clinical notes of three cases of *epithelioma of the tongue*, following the condition called by Mr. Hulke *Ichthyosis linguæ*. In each case the ichthyosis lasted nine to eleven years before the epithelioma appeared. All the patients were males over or close upon 50 years of age. Two cases denied any syphilis, and specific remedies produced no effect. The third had syphilis 17 years before, but never any secondary affection of the tongue or throat. In two cases the cancerous disease commenced upon an ichthyotic surface, and probably also in the third.

DUCKWORTH (6) briefly alludes to the syphilitic and to the gouty forms of psoriasis, and passes on to a discussion of various remedies and methods of treatment. In many cases where local treatment is resented it is because irritant remedies, however valuable in later stages, are inapplicable when the patches are small and hyperæmic, and when fresh spots are still appearing. Lemon juice is recommended locally in cases of obstinate palmar psoriasis not dependent upon syphilis. Internally, arsenical and alkaline remedies are principally relied upon, the latter in the gouty diathesis.

DUHRING (7) very properly protests against the application of the term *psoriasis* to the *squamous syphiloderm*, inasmuch as the two diseases, psoriasis and syphilis, have nothing in common,

remarking that we should never use the name of one disease adjectively to describe another. Much confusion has been introduced into dermatological literature by such proceedings.

GASKOIN (8), after mentioning that the *hereditary character of psoriasis* has been much exaggerated, affirms that its connection with Asthma forms the most conspicuous feature of this complaint. In 2,000 consecutive cases of skin disease (excluding those of a syphilitic or parasitic nature) asthma was present in 141, of which 56 were cases of psoriasis. The term asthma, it may be remarked, is used by G. in its comprehensive sense.

The cases of *Impetigo Contagiosa* presented to the Berlin Medical Society by OSCAR SIMON (9) were spoken of as having occurred, with others, apparently in epidemic form. The highest microscopic powers revealed no parasite such as described by Kohn (Kaposi), but showed the presence of the *Acarus folliculorum* and micrococci as is frequently the case in other skin diseases. In one patient spores and mycelia resembling the *Achorion Schönleinii* were found in a crust upon the eye-lid.

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## HYPERTROPHIES, ATROPHIES AND NEW FORMATIONS.

E. WIGGLESWORTH, JR., M. D.

1. **Jenks.** — Elephantiasis vulvæ. Amer. Supplement to the Obstetrical Journal, Vol. I, No. 2, Feb., 1874.

2. **Paul.** — Elephantiasis of the prepuce (*Eléphantiasis du prépuce et du fourreau de la verge*). Ann. de Dermatol. et de la Syph. Tome V. No. 1.

3. **Voillemier.** — Elephantiasis of the penis and scrotum (*Eléphant. du fourreau de la verge et du scrotum*). Annales de Derm. et de la Syph. Tome V. No. 1.

4. **Weil.** — Inflammatory papilloma (*Ueber das entzündliche Hautpapillom*). Vierteljahressch. f. Derm. u. Syph., 1874, I Heft.

5. **Vogel and Talko.** — Rare affections of the eye-lids (*Ueber einige seltenere Erkrankungen der Lider und der Bindehaut*). Geissler. Schmidt's Jahrb. Bd. 160, No. XII, 1874.

6. Kleinhans. — Vitiligo (*Ueber Vitiligo*). Bl. für Heilwissenschaft. II. 21, 22, 23. B. Wenzel, Schmidt's Jahrb. Bd. 160. No. XII, 1874.

JENKS (1) reports a case of *Elephantiasis vulvæ* in a woman, of 30 years, who remembered from childhood a small painless tumor of the right labium, which gradually increased in size. She menstruated at 15 years and subsequently, normally, but at the time of each catamenia the tumor increased in size, remaining non-sensitive. She had been a prostitute for 12 years, but was never impregnated or syphilized. At times the tumor has trebled in size and become hot, painful to the touch and oedematous, these symptoms gradually passing away. She was placed at first in the delirium tremens ward, and at night there occurred a profuse hemorrhage from the vagina. The tumor, seen the next day, was as large as a small orange, and hung from a broad pedicle, its origin, near the clitoris, involving the anterior third of both labia. Its surface was deeply fissured and rosy red, the growth slightly sensitive and oedematous. The left labium was swelled and infiltrated with a resistant mass, as large as an almond, near the posterior commissure. The perinæum was the seat of a similar growth projecting one-half an inch along the median line, and around the anus two similar ones hung from broad bases of attachment to the integument. The surfaces of all were moist, the inguinal glands swollen and indurated. The large tumor of the right labium when incised proved to be a firm fibrous mass, scantily supplied with blood vessels, pervaded with fissures, infiltrated with serum. Microscopically the tumor consisted of interlacing bundles of delicate fibre cells, the nuclei of which became visible upon the addition of acetic acid. The clot formed by the bleeding from the right side of the vagina separated on the third day, leaving a deep cavity, with irregular, jagged edges. The patient died, four weeks after admission, from intercurrent pneumonia, with uncontrollable diarrhœa. Dr. Jenks quotes Rokitanski, Virchow, and others, in support of his diagnosis, and considers "the oozing tumor of the labium" of Sir Charles Clarke as identical with the condition under consideration. As regards the vaginal hematocoele, Dr. Jenks is supported by recorded cases in his disagreement with Velpeau, who considers it nearly as common in the non-pregnant woman as during pregnancy. In the former case, as here also, it is always of traumatic origin.

WEIL (4) describes, with admirable conciseness, a remarkable case of *inflammatory papilloma of the skin*, a very rare affection. A day laborer, aged 73, healthy until five years before, had at that time an abscess over the left hip and, a year later, one in the right groin. Each of these opened, and closed after six weeks. Three years ago one appeared in the soft parts of the left buttock, opened in several places, and has since always secreted a small amount of yellowish pus. A year later a small tumor appeared just inside the left nipple, and soon broke, forming a fistula. One year ago a nodule formed about an inch above the *processus xiphoideus sterni*, its integument dark blue. This soon cracked, began to ooze, and changed into a flat cauliflower excrescence, which attained its present size after about four months' growth. [Its shape and size is that presented by the flat surface of half of a large Bartlett pear, about an inch across at the smaller end,  $3\frac{1}{4}$  inches across the body of the pear, and 5 inches in length.] The papillary layer is exposed, the papillæ hypertrophied and in many places fused either above or below, the interstices secreting a dark yellow fluid. The border of the patch consists of protuberances, bluish, full of sinuses, painful on pressure, and secreting a pus-like fluid. Microscopically the papillæ are covered by a thick, well-defined layer of epithelium. The papillæ proper are filled with cells and, in many places, pigment granules, and vessels are abundant. The patch gradually spread, but, after being scraped out, healed rapidly by granulations from the periphery.

VOGEL (5) describes a case of *amyloid degeneration of all the lids*, but chiefly of the left underlid, of a man aged 33. Threatening entropion was relieved by an operation. The excised cartilage showed a luxuriant granulation tissue (round cells) in the fibrous tissue which surrounds the cartilage, the fibres were thickened, as also the walls of the vessels. Protrusions from the connective tissue had penetrated and caused absorption of the cartilage, the remaining parts of which had lost their proper structure and gave the chemical reaction of amyloid degeneration.

In article upon *pigment atrophy*, KLEINHANS (6) draws, from 37 cases observed by Dr. Levy, the following conclusions: *Vitiligo* is more common in men than women; occurs in both white and colored races; is rare in children; occurs often from 10 to 20 years of age; afterward less often. It is found with all constitu-

tions and temperaments, more especially in the "biliary." Brunettes are more subject to it than blondes. It is common to all climates and professions; does not result from mental affections; is possibly hereditary, in which case it tends to extend; is due to the same causes as excess of pigment in the skin, and especially to syphilis. For the therapy local blistering is recommended.

7. **Payne.**—Origin and relations of New Growths. Goulstonian Lectures, Brit. Med. Jour. No. 638, et seq., 1874.

8. **Milton.**—Chelis and Lepra. New York Med. Journ., Feb., 1874.

9. **Geber.**—A rare form of Nævus (*Ueber eine seltene form von Nævus der Autoren*). Vierteljahressch. für Derm. und Syph., 1874, I Heft.

10. **Kesteven.**—Case of sudden death quickly following the injection of perchloride of iron into a nævus. Lancet, Feb. 7, 1874.

11. **Von Someren.**—Leprosy. Med. Times and Gazette, Mar. 28th, Apr. 3d and Apr. 18th, 1874.

12. **Legg.**—Xanthelasma of Tongue. Path. Society of London; Lancet, Feb. 7th, 1874.

13. **Murchison, C.**—Xanthelasma in connection with derangement of the Liver. Brit. Med. Jour., Apr. 25, 1874.

14. **De Morgan.**—Cancer. Med. Times and Gazette, Mar. 7th, 1874.

15. **Gale.**—Removal of Epithelioma of the lower lip by the elastic ligature. Lancet, Jan. 17th, 1874.

16. **Thompson.**—Fungous tumor of mamma removed by the elastic ligature according to Dittel. Lancet No. 1, 1874.

17. **Downie.**—Case of Madura foot. Indian Med. Gaz.; Edinb. Med. J., Apr., 1874.

Although PAYNE (7) in his lectures before the Royal College of Physicians has not restricted himself simply to the consideration of *new growths of the skin*, but has treated of the whole group which Virchow distinguishes as *pseudoplasmen* or true growths (*Gewächse*), we may yet call the attention of dermatologists to his lectures as among the ablest we have ever met with in the English language.

Under the heading *Chelis and Lepra* MILTON (8) describes a case of *true cheloid* (Alibert) occurring on the shoulders, on the site of an injury, and tending to subside under the action of caustic soda; also, three cases of, not leprosy (*Lepra Arab.*, *Elephant. Græcor.*), but *psoriasis*, and one of (probably) *lupus*.

VAN SOMEREN (11) adds his testimony to that of the best recent observers of *Leprosy* as to its incurability, but holds that it may be ameliorated by hygienic conditions and tonics, and that the oil of the cashew nut tends to disperse the tubercles. He regards the disease as non-contagious and advocates non-isolation of patients, forgetting that this measure is rendered necessary by the fact that the disease is hereditary.

WICKHAM LEGG (12) showed, at a meeting of the Path. Society, a specimen of hydatids of the liver, omentum and recto-vesical pouch, which had been accompanied by jaundice and *Xanthoma multiplex* especially on each side of the tongue, which is rare.

DE MORGAN (14) believes in the local rather than the constitutional nature of *cancer*. The cells may travel along the lymphatics to the glands, or through the surrounding tissues, or pass into the blood vessels, and thus into the general current. The diffusion of cancer once formed is thus accounted for without the need of any pre-existing or concurrent disease of the blood. It is difficult to account for the fact that after removal there may be no reproduction for years, but it is quite as difficult to account for the quiescence of the blood during this long time as for that of the cancer germs. And in hereditary cases of lipomata or cysts the rudiments would seem to have been present from the first. Moles, warts, etc., may remain without change for fifty years, and then become the seats of cancerous growths. Yet he would not imply that in cancerous patients there is no special disposition to tissue change in some, but not in all, of the structures of the body. In many persons no amount of irritation will give rise to cancer, but in some there would probably be no cancer unless irritation were applied, and the same remark applies to warts. The question remains, why have diseases seats of election at all? Another phenomenon is the arrest of the cancer growth and the gradual wasting of the diseased mass. It is only shifting the difficulty to say that this takes place in obedience to the law of local atrophy or from inherent want of organizing power. Finally, why is cancer, if a blood disease, so preeminently a disease of women, 90 per

cent, perhaps, occurring in the uterus and mammary glands? Other forms of tumor are nearly as prevalent in one sex as in the other.

GALE (15) operated upon a gentleman æt. 64 for an *epithelioma* of four years standing by transfixing the lip in the centre where the tissue was healthy, and inclosing the growth by two elastic ligatures. Morphine,  $\frac{1}{8}$  gr., was injected under the skin night and morning. The pain was but little, if any, greater than that from the disease itself. By the 14th day both halves were detached. The wound left was a mere line with a healthy looking surface.

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## HEMORRHAGES AND NEUROSES.

A. VAN HARLINGEN, M. D.

1. **Fox, Tilbury.**—Purpura urticans. *Lancet*, Feb. 7, 1874.
2. **Humbert-Molliere.**—Clinical researches on the nosography of purpura hemorrhagica (*Recherches cliniques sur la Nosographie*, etc.), *Annal. de Derm. et de Syph.*, No. 1 and 2, tome V.
3. **Lewis, S.**—Notes on purpura among the children of the poorer classes in Liverpool. *Brit. Med. Jour.*, Mar. 21, 1874, p. 375.
4. **Williams, W.**—The alleged occurrence of purpura in chilren. *Brit. Med. Jour.*, April 18, 1874, p. 512.

Dr. HUMBERT-MOLLIERE, gives (2) a series of ten cases of purpuric disease, with remarks. The question proposed at the beginning of his investigations was whether the malady formerly called *morbus maculosus Werlhofii*, and at present usually known as *purpura hemorrhagica*, is a morbid entity, or whether the petechial condition is merely a symptom proper to many affections characterized by profound alteration in the composition of the blood, and by disorders of that portion of the nervous system which presides over the contraction of the smaller vessels.

After a review of the history of the affection since the date of its earliest description by Werlhof, and a general allusion to the various opinions as to its pathology current at the present day, Dr. M. presents the notes of his cases at some length, and terminates his paper with the following conclusions based upon his experience:

- I. Werlhof's disease is not a morbid entity like acute rheumatism or the eruptive fevers.
- II. Eruptions of purpura may be met with in a great number

of diseases, and in subjects presenting the most varied constitutions and general conditions, from perfect health to the most advanced cachexiæ.

III. The cause of these hemorrhages should be attributed in a great number of cases to a fragility, innate or acquired, of the capillary vessels of the skin and of certain mucous membranes.

IV. This fragility varies greatly according to the individual. It may be considered in a great number of cases as a veritable but mild form of the hemorrhagic diathesis of the Germans (hæmophilia).

V. Alteration of the blood by any disease whatever only augments the chances of hemorrhage.

VI. Finally, from a therapeutic point of view, the employment of mineral acids has always given excellent results in the cases described.

[From an examination of upwards of 900 children, LEWIS (3) concludes that more than 60 per cent of the children of the poorer classes in Liverpool suffer from *purpura simplex*, which appears in the form of minute spots, chiefly on the thorax, throat, and upper arm, and in some cases on the face; rarely on the scalp, abdomen and legs; never on the feet. He diagnosticates them from flea-bites by the absence of the dark central point marking the puncture with the proboscis, by their smaller size, by their not disappearing under pressure, and by their longer continuance. Bleeding from the nose and bowels occurred in some of the cases. Ergotin, in doses of one-eighth grain for young children and one to two grains for adults, was employed.

WILLIAMS (4) attributes Lewis' supposed cases of *purpura simplex* to flea-bites, and, after bringing forward arguments to that effect, details seven cases out of from thirty to forty of which he had taken notes. Ed.]

1. **Jones, C. H.** — Hyper-excitability of the skin and paresis. Brit. Med. Jour., March 28, 1874.

2. **Lancereaux.** — Trophoneurosis. Gaz. Med. de Paris, No. 20, May 16, 1874.

3. **Schuppel.** — General anæsthesia. Archiv. für Heilk. Vol. XV, 1874, pp. 44-62. Centralb. Med. Wissensch, No. 19, 1874.

4. **Duhring.** — Pruritus hiemalis — an undescribed form of pruritus. Phila. Med. Times. January 10, 1874.

5. Larnadrid, Julio.—Pruritus hiemalis. Phila. Med. Times. Jan. 21, 1874.
6. Murchison, C.—Pruritus from hepatic derangement. Brit. Med. Jour. April 25, 1874.
7. Purdon, S. H.—Pruritus vulvæ. Dub. Med. Jour. June, 1874, p. 81.

In this excellent monograph on *pruritus hiemalis*, Dr. DUHRING (4) deals with an affection of the skin which had previously escaped recognition as an independent form of disease. It consists in a peculiar state of irritability of the skin which manifests itself in the autumn or even as late as the winter season, generally about the time of frost. Its duration varies from a few days or weeks to months, but it never persists after the cold weather has passed, always disappearing with spring, frequently to return again with the autumn. It is found at all ages and in both sexes, and may attack any or all parts of the body, though showing itself most usually and typically on the lower extremities.

The affection is characterized by a certain itching of the skin which comes rather suddenly in the course of a few days, and which may be better described as an itching, smarting, tingling, burning sensation, as though the person were clothed in new flannel or woolen wear, and at the same time were rubbing and chafing the skin. The amount of irritation varies with different cases, it may be very slight or in some instances so severe as to cause great annoyance and distress; a striking peculiarity is its tendency to become aggravated at night, and it is when taking off the clothes on retiring that the itching becomes most noticeable and severe. Usually the patient is kept awake some time by it, but sleep finally ensues in all but the severest cases, and in the morning but little of the pruritus exists, and it does not ordinarily recur until the next evening.

There is no *primary eruption* of any kind connected with the affection either at its commencement or at any time during its course, but there are certain *secondary lesions* which show themselves several days after the first appearance of the disease, and at that stage of the affection when the patient usually presents himself for treatment. It is important for diagnosis to remember this point; the skin may now be rough and harsh, resembling xeroderma or mild ichthyosis. Many of the hair-follicles are red and more or less inflamed and irritated, with an accumulation of

epidermis and sebaceous matter about their openings. Many of the hairs are also torn and broken off short, close to their follicles. Here and there over a considerable surface the whole skin looks red and irritated, and shows unmistakable evidence of having been torn or wounded by the finger nails. All these appearances are, as has been said, secondary; they are effects of the pruritus and produced solely by the patient. It is of the greatest importance to distinguish between these and the primary symptoms which are subjective alone, if we would make a correct diagnosis.

As to the *etiology* of the disease, Dr. Duhring regards it as intimately associated with atmospheric changes, and as an affection of cold weather. It occurs in persons otherwise in excellent health, is unconnected with any derangement of the nervous system, constipation of the bowels or abnormal condition of any of the secretions. It is found equally among all classes, both rich and poor, dirty and clean. It is as frequent among bathers as among those who never use a bath. The disease is not caused by any peculiarity in the clothes worn, for clinical experience proves (and upon this point Dr. D's investigations were usually searching) that the affection commonly exists upon persons who are most careful in avoiding harsh, irritating underclothes, and also in those who wear only the finest linen next to the skin.

As regards *diagnosis*, lichen pilaris and prurigo, as understood in this country, are the two diseases with which it may be confounded. Lichen pilaris, however, is a disease of the hair-follicles alone, consisting of an accumulation of epidermis and sebaceous matter about their openings; it may or may not be accompanied by itching; it occurs on the outside of the thighs most generally, and finally it usually affects persons who do not bathe. As regards the true prurigo of Hebra, the pathological lesion of this disease, the distinct plastic papules are sufficient to distinguish it at once. The trouble once recognized as a pruritus there is little danger of confusing it with any of the other forms. The fact that the disease of which we are speaking is an affection of the fall and winter season stamps its individuality at once and justifies the designation "*hiemalis*." Its almost exclusive habitat—the lower extremities—is another peculiarity which it is important to remember, as well as the particular parts of the limbs involved, the almost entire freedom during the day, and the constant attack towards night, and especially upon taking off the clothes.

In reference to *treatment*, Dr. D. recommends warm baths

before retiring, and especially baths containing carbonate of soda, cold bathing, Turkish baths; internal treatment has proved unavailing. Everything in the way of clothing, hot rooms, etc., tending to irritate the skin must be avoided. Dr. Duhring's paper has been criticised in some quarters as "a description of a very common affection," and as one "long recognized." While this may be true the credit certainly belongs to him of having first described the affection in an intelligible manner, and pointed out its distinctive features.

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## PARASITIC DISEASES.

H. G. PIFFARD, M. D.

**Malassez and Courreges.** — Fungus in Alopecia areata. Archives de Physiol. May, 1874.

Most observers have been content heretofore with examining the hairs of and adjoining the affected parts, with, it is needless to say, almost invariably negative results. The above named observers, however, examined not only the hairs but also the fine scales upon the surface. The scales were collected by gentle scraping, and were agitated with ether and absolute alcohol to extract all the fatty matters. Finally they were well washed with fresh portions of absolute alcohol, and mounted in a one-per-cent solution of carbolic acid. The hairs were, in like manner, deprived of all oily matter, and mounted in a mixture of equal parts of glycerine and water, slightly acidulated with acetic acid. Using moderate powers, Malassez found upon the scales a large number of spherical and ovoid, highly refractile bodies, not larger than 4 to 5 *micra*.

The uniformity in size of these bodies, and the fact that they had resisted the action of the ether and alcohol rendered it improbable that they were oil globules. Osmic acid also failed to affect them. The largest of these spores, for such Malassez considers them, measured 4 to 5 micra. These bodies were double contoured, and many of them possessed small buds projecting from some portion of their circumference. Other spores were annular, and others again formed incomplete rings. Other spores, measuring 2 micra, had the same general characters as the above, except the double contour, and others again of much less

diameter possessed the spherical form only. These different spores were sometimes found singly, at other times in groups and chaplets.

Upon the hairs these spores were rarely discovered, and when found their presence appeared to be accidental. The hairs, however, were often faded, atrophied or fragile, but their structure was not sensibly modified, nor even their epithelium destroyed. Examinations of thin sections of the skin exhibited the spores in the superficial layers only of the epidermis. But the epidermis which surrounded the hair-follicles was very much hypertrophied, being in some instances at least fifteen times thicker than normal. No mycelium or any evidence of fructification was discovered.

MM. Courrèges and Malassez found these appearances in every case examined.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### GENERAL QUESTIONS IN SYPHILIS, THERAPEUSIS, ETC.

R. W. TAYLOR, M. D.

1. **Bardinet, M.** — Syphilis communicated by the finger of a midwife (*Syph. commun. par le doigt d'une sage-femme*). Annal. d' Hygiene, pub. July, 1874.

2. **Brouardel.** — Lesions of Syphilis which may cause death (*De quelques uns des accid. Syph., etc.*). Gaz. des Hôp., Nos. 39, 41 and 43; 1874.

3. **Carenzi, B.** — Innesto del virus syph. nei bovini. Giornale Italiano delle Mal. Ven. e del. pelle. June, 1874.

4. **Chapuis, S.** — Gummy tumors of the tongue (*Des tumeurs gomm. de la langue*). Thèse de Paris, 1873.

5. **Dubuc.** — Herpetiform multiple syphilitic chancre. Annal. de Derm. et de Syph., No. 4, 1874.

6. **Fournier, A.** — Tertiary Syphilis (*Considérations générales sur la syph. tertiaire*). Gaz. Hebdom., No. 21, 1874.

7. **Fournier, A.** — Gummy tumors (*Gommes du tissu cellulaire*). Progrès Medical, Nos. 22, 23, 24; 1874.

8. **Godebert, E.**—Syphilitic strictures of the rectum (*Sur les Rétrécissements syph. du Rectum*). Thèse de Paris, 1873.

9. **Hamilton, John.**—Lectures on syphilitic osteitis and periostitis. London, 1874.

10. **Moreau, L.**—Tertiary Syphilis of Serous Sacs (*Des affect. tertiaires des bourses sereuses*). Thèse de Paris, 1873.

DUBUC (5) reports six cases of *syphilis in which multiple initial lesions* were observed. Their appearance was similar in all respects to the *chancre érosif* of Fournier, and only differed in point of size from the chancrous lesion of Diday. Appearing after the typical incubation period, they have a diameter of a line, look like very slight, round excoriations, quite red, bleeding freely if manipulated, and having a base in which the induration is slight and difficult to determine, but this may develop in them. Secretion is scant and serous. Situated on the prepuce and glans they occur in numbers of from five to fourteen. Their diagnosis is difficult in the first stage, but the absence of itching or burning, their rather deeper color, and their chronicity, are points which will assist in distinguishing them from herpes. Besides these, there is soon observed typical adenopathy after the chancre, which, in its indolent character, differs from the inflammatory engorgement, attended with pain, which, in somewhat rare instances, accompanies herpes. The duration of the herpetic chancres in Dubuc's cases was from a month to six weeks in their uncomplicated condition.

There is a clinical point of some interest in this connection which the author does not bring out well, namely, that in subjects in whom the prepuce is long and tight, an original unique chancre may, from want of care, become inflamed, and, as a result, there are developed around it a number of superficial excoriations which might lead an inexperienced observer to conclude that there were multiple initial lesions.

There is so little that is really new in HAMILTON's work (9), and so much old matter which has already, many times before, been presented in a better and clearer light, that the necessity of its publication seems questionable. Perhaps a redeeming feature may exist in the chapter treating of osteitis of the orbital plates of the frontal bone, which contains interesting and suggestive cases. We are astonished at the description of a so-called yellow

tubercle due to syphilis and affecting the bones. This product is really dessicated gummy or granulation tissue, and should have been so termed without adding a new name to literature. The drawings are finely executed, and it is to be regretted that they do not illustrate more valuable text.

#### THE TREATMENT OF SYPHILIS.

11. **Foye, J. W.**—The treatment of syphilitic diseases by the mercurial vapor bath. Boston, 1874.

12. **Hutchinson, Jonathan.**—Use of mercury in syphilis. Lancet, 1874.

This handsomely printed little volume (11) is an epitome of the views of Parker and Lee as to the peculiar advantages of the *mercurial vapor bath*. No new views are advanced, and the chief value of the work is in the fact that it is more condensed than the originals. It seems that the author's enthusiasm for the treatment induced him to bring out the book. It will be of benefit to those who may need information on the subject. In reading over the illustrative cases given by the English authors, one is struck with the slip-shod manner in which they are reported, and in the details of some of them it is quite clear that a consecutive history of syphilis was not brought out by the physician.

**HUTCHINSON** on the *use of mercury in syphilis* (12). This is certainly one of the most carefully elaborated articles which have appeared for many years, evincing not only a clear and accurate knowledge of the disease, but also a practical acquaintance based on extensive experience with the necessary therapeutic measures. As an earnest appeal for the recognition of the value and necessity of mercury in syphilis, we have not read so able an article since the recent admirable lectures of Fournier were published. The author sums up his conclusions in an aphoristic form, which are here briefly stated in a somewhat modified form:

Mercury is, probably, a vital antidote to syphilis, capable of inducing a cure, as proved by cases being restored to health, and being rendered susceptible of renewed contagion.

The probabilities of cure depend upon the stage of development attained by the disease, and upon the perseverance with which mercury is used, it being necessary to introduce a considerable quantity for a long time. Ptyalism is not beneficial, can and

should be avoided, as it prevents a prolonged use of the remedy. Cases showing susceptibilities to the drug should be treated with reduced doses.

Mercury should be given as soon as the chancre shows any induration; many cases thus treated never show any secondary symptoms.

In cases in which secondary symptoms occur, they are milder if treated than they would be if not.

If mercury does not prevent, it exhibits a remarkable power in delaying, the second stage. Delayed outbreaks of the secondary stage indicate that the administration has not been sufficiently active, rather than that the mercury is inefficient.

The risk of tertiary symptoms is in ratio to the severity and duration of the secondary stage. It is probable that the tertiary lesions are less severe and less frequent in cases which have been treated by mercury.

Mercury cautiously given does not injure the health; and its local inconveniences may be avoided.

Statistics of syphilis, based on the ordinary methods of treatment, are worthless.

It has not been proved that in any particular form of syphilis mercury should be avoided, but it should be used cautiously in cases of ulceration.

Iodide of potassium has no efficiency in primary or secondary syphilis. Mercury is efficacious in some cases which have resisted the iodide.

The mode of administration is of no great importance provided the bad effects of the mercury are avoided. The doses usually given internally, are, for the most part, too large, necessitating a discontinuance of treatment. If one method does not proceed satisfactorily another should be tried. In difficult cases the vapor bath should be tried.

In the discussion of this paper before the Hunterian Society, the various prominent syphiliographers of London indorsed the author's views, Dr. Drysdale, however, dissenting.

It is well to remember that equally strong opinions and views can be cited in favor of not beginning a mercurial course until the secondary lesions manifest themselves, and that under those circumstances, results fully as favorable may be attained.\*

\* A large portion of this report crowded out.—ED.

## NERVOUS AND VISCERAL SYPHILIS.

E. L. KEYES, M. D.

1. **Althaus.**—Case of infantile syphilitic epilepsy.—*Med. Times and Gaz.*, April, 1874, p. 398.
2. **Broadabent.**—Syphilitic affections of the nervous system.—*Lancet*, 1874, Nos. 2, 4, 6, 8, Jan. and Feb.
3. **Bruberger.**—A case of syphilitic meningitis, with remarks on syphilis of the central organs. (*Ein Fall von meningitis syphilitica nebst Bemerk. über syphilis der centralorgane.*)—*Virch. Archiv.*, May, 1874, p. 285.
4. **Buzzard.**—Case of general syphilitic paralysis.—*Med. Times and Gaz.*, April, 1874, p. 413.
5. **Buzzard.**—Syphilitic nervous affections. *Monograph 8 vo*, pp. 148. London: Churchill, 1874.
6. **Cadell.**—Case of mental excitement during the secondary stage of syphilis.—*Journ. of Mental Sci.*, Jan., 1874, p. 564.
7. **Jones, H. W.**—Syphilis, hemiplegia, aphasia, recovery.—*Chicago Journal of Nervous and Mental Dis.*, Jan., 1874.
8. **Newington.**—Case of insanity dependent on syphilis.—*Journal of Mental Sci.*, Jan., 1874, p. 555.
9. **Reder.**—Contributions to syphilitic affections of the central nerve system. (*Beiträge zur Casuistik syphilitischer Affectionen des Central-Nervensystems.*) *Veirteljahresschr. für Derm. u. syph.*, p. 29, 1874, I Heft.
10. **Robertson.**—(Alexander.) Epileptic aphasia and hemiplegia; colored vision; syphilitic (?) origin.—*Brit. Med. Jour.*, April 18, 1874, p. 515.
11. **Roof.**—A case of insanity from syphilis.—*Phil'a Med. and Surg. Reporter*, Feb. 1874, p. 201.
12. **Luke.**—Two cases of syphilitic insanity.—*Journ. of Mental Sci.*, Jan., 1874, p. 560.
13. **Wilks, Samuel.**—Two cases of insanity dependent on syphilis.—*Jour. of Ment. Sci.*, April, 1874, p. 38.

ALTHAUS' case (1) of *infantile syphilitic epilepsy* is interesting from two points of view: first, because the nature of the malady not being at once made out, long-continued treatment was ineffective, [while prompt and, it appears, a radical cure followed a correct diagnosis and the use of the iodide of potassium]; and secondly,

because the case was one of inherited syphilis, although the boy was nine years old.

These Lettsomian lectures of BROADABENT (2) *on syphilis of the nervous system* are garnished with some well-observed illustrative cases, and represent pretty accurately the present state of our knowledge of the nervous symptoms due to syphilis. B. maintains the opinion that it is chiefly where the secondary symptoms have been light in character or even absent, or where tertiary symptoms arrive very early that nervous symptoms appear; citing Gros & Lancereaux, Braus, Buzzard and Moxon, in corroboration of this opinion. He draws attention to local syphilitic sclerosis of the cord of the posterior columns as causing locomotor ataxia; of the anterior wasting paralysis; but expresses a strong doubt as to syphilis being by any means a common cause of these affections, especially the latter. B. believes that acute general or local myelitis may be caused by (especially secondary) syphilis, and that spinal meningitis due to syphilis is less common than myelitis from the same cause. Special attention in connection with cerebral syphilis is directed to double optic neuritis, hemi-spasm, and disease of the walls of the vessels leading to thrombosis. The intellectual and emotional manifestations of brain syphilis are only touched upon lightly, while no mention is made of the recent localization of specific pathological changes upon the sympathetic nerves and ganglia by Petrow.

BRUBERGER (3). *Syphilitic Meningitis.* This patient, aged 30, two years after infection, without previous headache, fell suddenly in the road while walking, and remained some minutes unconscious. He recovered and was not paralysed, but rapidly became weaker and weaker until in 8 days he had lost all power of muscular motion, being unable to move even the fingers or toes. Sensibility and intelligence, perfect; no pain; electrical excitability scarcely diminished; pupils, normal; slight sensitiveness on pressing the skull, none elicited on pressing the spine. Treatment failed. The patient got bed-sores, perineal abscess, etc.; the sphincters relaxed and he died. Autopsy revealed meningitis in the cervical portion of the cord, the membranes being thickened, matted together, and adherent to the substance of the cord and to the bone. There were hemorrhages into this region of the cord, atrophy of the grey substance, and increase in size of the central canal. There was extensive basilar meningitis, the pia

being thick, grey and gelatinous. The walls of the vessels of the brain were thickened and knotty. It is noticeable in this case, that with these extensive lesions there were no paralysis of special nerves, no convulsions, *no pain*, and that the sensibility of the whole surface was intact.

In this case of BUZZARD's (4), æt. 46, there was *general syphilitic paralysis* of both extremities and of the facial nerves, incomplete paralysis of respiration, deglution, of the right sixth nerve, and general cutaneous anesthesia. The attack came on gradually, and no positive history of syphilis could be gained. Ten-grain doses of iodide of potassium produced improvement in 24 hours. The dose was run up to 3 j, some subcutaneous injections of chloro-albuminate of mercury used, and in less than six months the patient was entirely well.

No. 5 is an excellent text-book for popularizing much needed knowledge of the subject of *syphilitic nervous affections*.

The interest in the first of the two cases of REDER (9), consists in the fact that locomotor ataxia was the malady ascribed to syphilis, that it yielded promptly to treatment, but as the latter was seemingly always suspended when the symptoms ceased, relapse followed relapse, until finally, the symptoms became very severe, failed to respond to treatment, and the patient became a permanent cripple.

**14. Barety.**—Atrophy of the interosseous muscles of the hand in two syphilitic patients. (*Observation d'atrophie des muscles interosseux de la main chez deux syphilitiques.*)—Annal de Derm. et de Syph., 1873-4, Nos. 3 and 4.\*

**15. Kunze.**—Syphiloma of the liver and porta hepatis. (*Syphilome der Leber und Porta hepatis.*)—Deutsch. Zeitschr. f. pract. med. 12, p. 102, 1874.

**16. Mauriac.**—Early gummy syphilides resisting iodide of potassium. (*Syphilis gommeuse précoce et refractaire à l'iodure de potass.*)—Gaz. des Hôp., June 11, 18, 23, 25, and July 2, 1874.

**17. Stewart, T. Granger.**—Case of waxy and syphilitic disease of the liver, with ascites; recovery after frequent tapping.—Med. Times & Gaz., Jan. 1874, p. 121.

**18. Thierfelder.**—Syphilis of the liver. (*Syphilitische Lebernarbe, Syphilis der Leber.*)—Atlas der path. Histol., Leipzig, 1874. 3d Lief. Tafel xvi, figs. 2 and 2 a, and Taf. xvii, figs. 3, 3 a, and 4.

\* Remarks crowded out until next number for want of space.—ED.

**19. Thierfelder.**—Syphilis of the lung. (*Syphilis der Lunge.*)—Atlas der path. Histol. Leipzig, 1872, 1 Lief. Tafel v, fig. 3.

**20. Weil.**—Tumors of the spleen, early in syphilis. (*Ueber das Vorkommen des milztumors bei frischer syphilis.*)—Centralbl. für d. med. Wissenschaft, 1874, 12. p. 177.\*

**21. Weil.**—Splenic tumors in syphilis, and percussion of the spleen. (*Ueber das Vorkommen . . . . . nebst Bemerk. über die Percussion der milz.*)—Deutsch. Archiv. f. klin. med., May 15, 1874.\*

(The following reports have been necessarily delayed until our next issue: Nomenclature Diagnosis, Therapeutics and General questions, by E. B. Bronson; Diseases of the Glands, by Louis A. Duhring of Philadelphia; Inflammations; Roseola, Urticaria, Herpes, Pemphigus, etc., by James C. White of Boston; Eczema, by F. D. Weisse; Electro-therapeutics of skin diseases, by Geo. M. Beard; also General Syphilis, by F. J. Bumstead; Infantile and Congenital Syphilis, by Fred. R. Sturgis; Syphilis of the Throat and Larynx, by Geo. M. Lefferts; and Gonorrhœa and its Complications, by Robert F. Weir; also portions of Dr. Taylor's and Dr. Keyes' reports.—EDITOR.)

\* Remarks crowded out until next number for want of space.—ED.

## Reviews and Book Notices.

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*Elementary Treatise on Diseases of the Skin (Traité Élémentaire des Maladies de la Peau.)* By A. GAILLETON, Paris, 1874.

WHEN we took up this book for review and read in the preface, "Normal and pathological anatomy and physiology alone can furnish the certain and necessary guide amid this confusion" (existing in the study of skin diseases), we had great hopes for it, although French, and when on reading further the first chapter was found to be devoted to the anatomy of the skin, and a subsequent one to its pathological anatomy, we rejoiced indeed that a French teacher had broken the bonds of *diathesis* and had attempted to present cutaneous pathology in its true light. We are sorry, however, to find the work still largely occupied with considerations based on arthritic, herpetic and scrofulous diathesis, and filled with quotations from and reference to French authors to the exclusion of those of other countries.

But the work is a great advance in the right direction, and has many points of interest, presenting the subject in truly an elementary manner. The first part, comprising one-half the book of 300 pages, treats of general subjects, in the following chapters: Anatomy of the skin, symptoms, pathological anatomy, etiology, diagnosis, treatment internal and external, classification. The second part is a succinct resumé of the diathetic and other causes of eruptions, scrofula, gout, rheumatism, syphilis, alterations in the blood, etc., together with a chapter of nineteen pages on nerve disorders and lesions, and the cutaneous maladies resulting. This last deserves more than a passing notice, as it is carefully written, and presents, more than any other work on dermatology, the subject of the relations of the nervous system to the skin in a clear light, substantiating every statement by cases original or quoted. This chapter alone would render the book invaluable.

In the preface the author mentions a third part of the work containing descriptions of individual maladies of the skin, which he proposes to divide into diseases of the derma, those of the epidermis and nails, and those of the glands, with a closing chapter on parasitic affections; we regret to say that this part is omitted

entirely, probably to appear later in separate form. We hope it may appear, for Dr. Gailleton is an advanced writer, already known through the periodical literature, and will, we trust, while representing the French school, disengage himself in a measure from the trammels of herpetism, arthritism, etc., by the liberal method of study he has evidently employed. Elementary works of this kind, laying well and rightly the principles of dermatology accompanied by abundant clinical presentation, will do much to place this branch on a sound and practical basis. The book is without an index or even a table of contents, which impairs its value as a work of reference.

*On Lupus Disease of the Skin, and its treatment by a new method.*

BALMANNO SQUIRE, M. B. F. L. S. J. & A. Churchill, 1874, pp. 31.

The object of this brochure is the presentation of a plan of treatment which the author claims has furnished him the best results in this troublesome disorder. And this is, in brief, the external application of iodine in rectified spirit, in a strength varying from the tincture of the pharmacopœia even to the strongest possible solution, assisted by iodide of potassium, as circumstances require, graded always so as to produce "a sub-acute inflammation of the affected skin as distinguished from the chronic special inflammation with which it is already affected." It is very important that there should be no breach of surface, all cracks or raw spots must be healed first. The treatment deserves a trial at the hands of the profession, and we will be glad to record cases of its success or failure. The monograph will repay perusal. It would seem, however, that the author does not include as lupus the lupus erythema-todes of the Germans, which we see so often in this country.

*Vierteljahresschrift für Dermatologie und Syphilis.* Drs. F. J. PICK and HEINR. AUSPITZ, editors, Braumüller, Vienna, 1874. Vol. I, No. 1.

We welcome heartily the re-appearance in a new dress of our old and valued friend the "Archiv für Dermatologie und Syphilis," for the "Vierteljahresschrift" is but a new series of the same with certain changes necessitated by a change of publishers. It contains as usual a large amount of original matter which is noticed in our digest, and its review of literature is as full and satisfactory as ever. Its cessation, as reported, would have left a blank in periodical literature not easily filled.

Owing to want of space other reviews and bibliography have been reserved for next issue.—ED.

## EDITORIAL.

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In presenting the Archives of Dermatology to the profession, the Editor would offer a few words as to its scope and plan.

There are no cases, we believe, which, as a rule, afford the general practitioner greater annoyance in diagnosis, prognosis, and treatment than those of skin and venereal diseases, while few maladies cause the patient more mental distress than these, and for none are they really more desirous of a correct and successful treatment. That there is any thing inherently difficult in this branch of practice above others, no one will assert, and to the experienced it is a matter of surprise that it should be obscure to any. Still the feeling is very common among the profession at large that they would rather treat any diseases than these.

The reasons for this are, the small amount of instruction given in this branch in the colleges, and the dearth of clear, accurate and practical literature on the subject, together with the confusing nomenclature and theories existing, which result from the admixture of ideas of many different schools of Dermatology. The first-mentioned difficulty is being in a measure remedied by a more enlightened policy in many of our medical colleges, or may be overcome by an attendance on the dispensaries in our large cities. The second we hope to assist in removing by furnishing practical articles and a comprehensive review of the subject, while in the matter of classification and nomenclature we desire to simplify matters by adhering to one system, by giving synonyms and by avoiding useless multiplication of terms and alterations in spelling.

We would expressly state, that while the "Archives" is

intended to record, as far as possible, all that is new and valuable in the department of skin and venereal diseases, it will be prepared rather with a view to the wants of the general profession than to those of the specialist — that its aim will be to simplify the subject and its general bearing of a practical character.

Our subject-matter will be arranged as follows:

- I. Original Communications.
- II. Transactions of the New York Dermatological Society,  
including papers, cases and discussions.
- III. Clinical Reports.
- IV. Extracts and Translations.
- V. Digest of Dermatological Literature.
- VI. Reviews and Book Notices.
- VII. Correspondence and Miscellanies.

Among "Original Contributions" and "Clinical Records" we desire to present not merely abstract articles and rare cases, of interest only to the specialist, but also such simple, practical papers, treating of common and every-day diseases, as will enable all to become acquainted with the subject, and such cases as will throw light on the same.

To this end we have secured the present or promised assistance of many whose names are well known to the profession, in addition to our list of Collaborators, given on the title page.

We trust that the "Transactions of the New York Dermatological Society," published officially in the "Archives," will prove especially interesting, as the papers and cases there presented during the past five years have often been of unusual interest. We would here explain that the announcement in the first prospectus, that the Journal is published "under the auspices of the New York Dermatological Society" was erroneous, the Society having no connection therewith, other than furnishing its transactions. The Editor is, therefore, alone responsible for the "Archives," and trusts that the names of the Collaborators will vouch sufficiently for the future of the Journal.

We shall not devote much space to "Extracts and Translations" from other journals, as the Digest will aim to give their substance, and only such will be inserted as are of unusual interest in their entirety, or do not admit of abridgement.

The "Digest of Literature" has been divided into that pertaining to skin diseases proper and that of lesions of venereal origin, and these have been further sub-divided and given into the hands of our Collaborators, who have kindly consented to furnish Quarterly or Half-yearly reports of their branches as the subject-matter demands.

In our Reviews of Books we will endeavor to give impartial judgment while we call attention to their contents; our Collaborators will assist in the reviewing, as occasion and subject requires.

Under "Correspondence and Miscellanies" we propose to open our pages to such matter as relates in any way to our subjects, not otherwise provided for, and we solicit discussion of topics of interest and items relating to our work.

The Editor cordially invites all who are interested in Dermatology in any of its branches to a support of the "Archives," trusting that it may thus be made the depository of much that is useful and instructive.

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We have received communications from Drs. McCall Anderson, J. K. Spender, J. L. Milton, Lawson Tait, James Morris, Wm. H. Van Buren, S. D. Gross, H. C. Hand, B. Joy Jeffries, W. H. Geddings, J. Collins Warren, Dyce Duckworth, Walter G. Smith and F. C. Curtis, which we would thus acknowledge.

"Brevity, indeed, upon some occasions, is a real excellence."

—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

JANUARY, 1875.

## Original Communications.

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### ON HERPES CONTAGIOSUS VARIOLIFORMIS.\*

BY FRANK P. FOSTER, M. D.

*Director of Vaccine Department, New York Dispensary.*

THE cases which form the subject of this paper occurred in four different families, all living together, for the time being, at a summer resort near Squan Beach, New Jersey, and constituting the sole occupants of the place. They associated freely with each other during the day, but were lodged in two separate houses, not more than twenty-five feet apart. The children of the various families played together almost constantly. The place was rather isolated, so that intercourse with people from other houses was limited to the occasional interchange of visits on the part of the adults.

The first cases occurred in the family of the proprietor, named C —. With one exception, the cases in this family did not come under my own observation, but the facts were given me by Mr. and Mrs. C. There were four children.

*Case 1.*—The first one attacked was J. C. C., a boy five years of age. As to previous eruptive diseases, he had had measles and scarlet fever, but had not had chicken-pox, and had not been vaccinated. The eruption was first noticed about the 10th of July. It affected

\*Read before the New York Dermatological Society, October 6th, 1874; the discussion thereon will appear in the next issue.—ED.

principally, if not exclusively, the forepart of the chin and the lower lip. It commenced with a single large vesicle at about the middle of the lip, near its red border. Other vesicles soon formed near it, and coalesced with it, so that in the course of a few days the affected part presented a continuous vesiculated surface, which was very sensitive to the touch. It remained in this condition for about a fortnight, and then quickly ended in a thick, dark-brown, continuous crust, which, on separating, left a perfectly healthy surface of skin. In this case, as in all the others, there was not the slightest constitutional disturbance at any time, nor did the disease leave any permanent marks behind it.

*Case 2.*—T. C., a boy three years old. He had previously gone through the same eruptive diseases as his brother, and had not been vaccinated. The eruption appeared during the first week in August. It affected the parts about the mouth, including both lips. The vesicles were numerous, but mostly separate, only a few coalescing, and no soreness was complained of. After continuing about a week the affection ended in incrustation, the crusts being thin and of a yellowish color, slightly red at some points.

*Case 3.*—E. C., a girl eleven years old, was also attacked during the first week in August. Her previous eruptive diseases were measles, scarlet fever, and small-pox. She had not had chicken-pox, and had not been vaccinated. She had only one vesicle, which was situated on the knee. It was said to have spread circumferentially, and to have shown somewhat the appearance of a ringworm. It lasted only four or five days, and ended in desquamation.

*Case 4.*—A. C., a girl nine years old, was attacked about the 22d of August. Early in the previous month she had undergone a mild scarlet fever, during which she was secluded in an out-house, which the children of the other families were not allowed to enter. She had two broad, pock-like vesicles on the lower lip, near the right angle of the mouth. I found them circular, rather more than half an inch in diameter, seated on a slightly-reddened, but not swollen, margin, and presenting very much the appearance of blighted vaccine pocks. They were declining at the time of my return to town (Sept. 5th), but were still vesicular. They gave rise to a slight smarting and itching.

The parents of these children were not attacked, neither were the servants of the household.

The second family consisted of Mr. M., his wife, his wife's mother, his three children, and three nurses, two of which latter, however, were discharged at about the time the disease first appeared at the house, and the third engaged thereupon, so that

only one of the nurses can be said to have been under observation after the disease broke out. Mr. M. spent only a portion of his time at the place. Concerning his family I did not obtain full particulars.

*Case 5.*—R. M., a boy two and one-half years old, affected with Pott's disease, was attacked during the first week in August. The eruption was scattered over the face and under the chin, in the form of small vesicles, and it did not affect other portions of the person. It soon ended in desquamation.

*Case 6.*—At about the same time, C. M., a girl four and one-half years old, was attacked with small vesicles around the mouth and on one arm. They soon ended in desquamation, without having given rise to any noticeable annoyance.

*Case 7.*—Mrs. M., the mother of these children, had one small, acuminate vesicle on the side of the face, which speedily ended in desquamation. The other members of the family had escaped the disease up to the time of their return home, about the third of September.

The third family comprised three adults, a lad of fifteen years, two children, and a nurse. The following cases occurred in this family:

*Case 8.*—R. G. F., three and a half years old. He had previously had no eruptive disease except measles. He was vaccinated within a fortnight after birth. He was attacked July 29; but I did not see the case (nor indeed any of the others) until August 15. A small, red papule appeared on the lower lip, near the left angle of the mouth, and disappeared the same day. A week later, a crop of similar papules appeared on the bridge of the nose and under the left eye, along the lower margin of the orbit. They were all dusted with a powder of starch, calomel and oxide of zinc, and ended in desquamation in the course of a few days, without (so far as my information goes) having become vesicular. About the 15th of August, two small papules appeared at the middle of the left cheek, one just in front of the left sterno-cleido-mastoid muscle, at about the middle of its course, one at the junction of the upper lip with the mucous membrane of the left nostril, and one on the dorsal surface of the left middle finger, near the root of the nail. At this time, as before stated, I first saw the case. To one of the papules on the cheek I applied tincture of iodine twice daily, for several days. The others were not interfered with. The former soon disappeared, while the latter all became large vesicles in the course of

a few days. The one on the cheek followed a course unmodified by injury or by any sort of interference. In the course of two or three days it had reached a diameter of nearly half an inch, and presented somewhat the appearance of a poorly developed vaccine pock. It was circular, with a large central depression, such as is seen after vaccination by a large scarification. The vesicular border was narrow, only very slightly raised above the level of the surrounding skin, rather whitish in color and noticeably flaccid. The raised portion of epidermis seemed very thin, as if it would break on the merest touch. The base was not swollen or hardened, and what little redness was to be seen, was a mere line immediately adjoining the vesicular margin of the lesion. This vesicle was sore to the touch; but otherwise did not seem to give annoyance. In a week or ten days from the first appearance of vesiculation, it ended in the formation of a thin, yellowish-brown crust, with peripheral desquamation.

The other papules likewise advanced to vesiculation; but they were repeatedly injured, and became very sore, particularly the one at the opening of the nostril, which seemed to extend backwards for a considerable distance along the floor of the nostril. Scabbing occurred early, and, from the repeated cracking of the scabs from external violence, healing was much delayed. Blood frequently exuded upon blowing the nose. The crusts had not entirely separated until the 29th of August. The subjacent skin then appeared perfectly sound; but the nasal mucous membrane remained slightly sore for a week or more longer. During the last week in August, several fresh papules appeared, mostly on the face and neck, but a few also on the upper and lower limbs; none on the trunk. As soon as they were observed, they were treated with iodine, with the invariable result of cutting short their progress. A few, however, escaped notice until it was thought that they had progressed too far for any benefit to result from the application of iodine. These advanced to the formation of vesicles, like the one on the cheek. When not injured, they seemed to give rise to no annoyance, and ended in desquamation.

*September 11.*—Nearly a fortnight having elapsed, a fresh crop of papules is now noticed, situated on the cheeks, the forehead, the chin, the left ear and elsewhere. Each papule is surmounted by an acuminate vesicle. Iodine applied several times during the day.

*September 12.*—Lesions now scarcely perceptible, being in progress of resolution. On the ear, however, a slight vesicular character is still apparent. Continue iodine.

*September 15.*—Lesions have wholly disappeared.

*Case 9.*—Mrs. F., the mother of R. G. F., was attacked about the 26th of August. Her previous eruptive diseases were measles and

chicken-pox. A single papule appeared on the dorsal surface of the right thumb, over the metacarpo-phalangeal joint. It advanced to vesiculation in the course of two or three days, acquiring a diameter of about half an inch, and showing the appearance of a tolerably well-marked vaccine pock of the seventh or eighth day, there being a flat central depression rather more than one-quarter of an inch in diameter, surrounded by a complete *bourrelet*, nearly a quarter of an inch in width, filled with clear lymph, and rather more prominent than in the other cases, deeper seated, and therefore less easily ruptured. The process of vesiculation was preceded and accompanied by deep-seated pain, with superficial itching and burning. There was no surrounding swelling, and the marginal redness was but a mere line.

*September 1.*—The vesicle was accidentally ruptured, causing severe burning pain, and giving issue to an abundant flow of clear, viscid lymph. With this lymph I inoculated my left forearm unsuccessfully. The lesion ended in the formation of a rather thick, yellow crust, which separated entire on the 6th of September, leaving a red surface of skin. The incrustation was accompanied with marginal desquamation. The redness persisted for about a week after the separation of the crust. Between the 11th and 15th of September, three new vesicles appeared at different times on various portions of the trunk. They were quite small, and one of them was acuminate. They ran a rapid course, ending in desquamation, without treatment.

*Case 10.*—G. E. M., a brother of Mrs. F., a lad of fifteen years, had previously had measles and rötheln.

*August 29.*—A papule at right angle of mouth. Iodine was applied, and the papule aborted with desquamation.

*September 3.*—Another papule has appeared, just above the outer end of the left eyebrow. It itched slightly, and was repeatedly injured by scratching, so that it became very sore. Vesiculation took place at the borders, forming a vesicle about half an inch in diameter.

*September 9.*—My attention is now first called to the lesion. The vesicle has dried up, and shows a patch of thin, light-colored incrustation, about three-quarters of an inch across, around which a collapsed *bourrelet* is still to be seen, which, in turn, is surrounded by a narrow red line. The border is slightly elevated. There is still considerable soreness. Another lesion (which first appeared September 7, but the early appearances of which were not observed) is situated on the outer aspect of the lobe of the left ear. It was at once injured by scratching. It now shows only redness and induration, with slight swelling, and causes considerable smarting. Another papule is noticed over the malar end of the zygoma of the left side, not more than one-sixteenth of an inch in diameter. Under

a lens, it shows an incipient *bourrelet* and a flat centre. It gives rise to some smarting.

*September 10.*—A new vesicle has appeared on the ulnar edge of the right wrist. It occupies the site of a slight wound, which had not quite healed. It is about one-third of an inch in diameter, and bears a perfect resemblance to a vaccine pock, except that the *bourrelet* is less elevated, and that there is no areola. It itches and burns a good deal. At this date, Dr. Bulkley saw the case, and inoculated me on the right forearm with lymph from the last-described vesicle.

*September 11.*—Wrist vesicle is somewhat larger. On the brow, the central crust has been torn off, leaving healthy (not reddened) skin. The collapsed *bourrelet* is still perceptible. The one on the ear is ending in resolution.

*September 12.*—Brow lesion shows marginal redness and desquamation, with perfectly healthy skin at the centre. (This may have been the same appearance that was noticed by the parents in case 3, and which they likened to that of a ringworm.) It still itches, but less severely. The vesicle on the right wrist has collapsed, and shows a glazed surface of dried secretion, through which, being perfectly transparent, the subjacent surface is seen to be simply reddened. The border is still vesicular, but collapsed. The diameter of the lesion is about half an inch. There is no itching, but it is very sore. A few scattered papules have appeared on the face, to which iodine is applied.

*September 13.*—Vesicle on wrist has increased somewhat in size, and has a well-marked vaccinoid look. The border has filled again, and again been ruptured. It is now exuding a perfectly clear lymph and is quite sore. The centre shows traumatic incrustation (that of the old wound). The lesion over the eye is now quite large and triangular in form, measuring an inch each way. The *bourrelet* seems to have enlarged and grown away from the centre, and the remains of it are still visible, although destitute of fluid contents. Marginal desquamation has begun. No new lesions have appeared. The papules on the face are declining.

*September 14.*—The crust has separated from the vesicle on the wrist, leaving a red, moist surface. The marginal vesicle is drying up. (I may remark, that in none of the cases did the *bourrelet* participate in the process of incrustation, but always ended in desquamation.)

*Case 11.*—Mrs. M., the mother of the last two patients, has had measles and chicken-pox.

*September 6.*—A number of papules appeared on the front of the neck, the trunk, and the lower limbs. They itched slightly, but did not become painful unless irritated by scratching.

*September 10.*—Very few of them have become vesicular, and all

are declining by resolution; only those which have been injured showing thin, light-colored central crusts, with marginal desquamation. In this case, the lesions were small and of short duration, disappearing without treatment.

*Case 12.*—M. C. F., sister of R. G. F., thirteen months old, has had measles.

*September 6.*—Numerous papules appeared on the face, particularly on the forehead, with a few on the wrists.

*September 7.*—Most of the papules are surmounted by acuminated vesicles. Many of these have ruptured, giving issue to a rather free flow of viscid lymph, mostly clear, but containing little pus-like masses. One of the lesions, situated on the left cheek, was broad, with a central depression and surrounded with slight redness and swelling, causing some irritation. Iodine applied to those lesions which are still only papular. I subjected some of the secretion to microscopic examination, but made out nothing worthy of note. Dr. Piffard, who saw the specimen after the lapse of a fortnight, detected certain filaments, which appeared to him to be similar to some of those which he has described as having been found by him in vaccine crusts and in the crusts of *impetigo contagiosa*.\*

*September 8.*—Lesions seem on the decline.

*September 9.*—No new papules have appeared; but they are quite numerous on the face, especially on the forehead. With the exception of the one on the left cheek (already alluded to as resembling a vaccine pock, which resemblance it still retains), the lesions are now nothing more than red swellings, about the size of half a pea (some larger, some smaller). One of them is surmounted by an impetiginoid pustule, with a central black point. This was ruptured to-day. None of those on the wrists have become vesicular.

*September 10.*—A few new papules have appeared on the ankles; iodine is applied to them. The red swellings mentioned in last note are rather smaller than yesterday, and some of them are surmounted by a black summit of dried blood. Two new vesicles have appeared on the left cheek, each about one-third of an inch in diameter, only very slightly elevated, and having the appearance of a blighted vaccine pock. There is one new vesicle on the left ankle, acuminated and surmounting a small, red elevation. I opened it, and found clear but very scanty contents, with which I inoculated my left forearm. The case was seen to-day by Dr. Bulkley.

*September 11.*—Lesions still declining. No new ones.

*September 12.*—A new lesion appeared on the end of the nose last night. It looks white at the border, and red within. It is about half an inch in diameter, and is without perceptible elevation. All

\* *Impetigo Contagiosa; its Parasitic Nature.* By Henry G. Piffard, M. D., etc. *New York Med. Jour.*, June, 1872. P. 623.

the other lesions are declining by resolution. Applied iodine to the new one.

*September 15.*—A few new papules have appeared on the right cheek. Iodine applied to them. The old ones are in process of resolution, but the redness persists longer than in the other cases. In this case, as well as in case 10, the subsidence of the disease was followed by successive crops of small papules on the face, which have not yet (October 3) entirely disappeared, but which show no disposition to vesiculate.

The remaining family consisted of Mrs. G., three adolescent daughters, and an uncle, together with an old colored nurse. Of these, one of the daughters had one pock, situated on the forehead. The young lady returned to town soon after it appeared, so that the case was not sufficiently observed to enable me to furnish its features.

In relating these twelve cases, I have incidentally mentioned several inoculations of my own person. The facts in regard to them were as follows: August 22d, morning—I opened a well-developed vesicle on the person of R. G. F. (Case 8), but obtained only a very scanty amount of secretion. With this I inoculated myself on the left thigh. The inoculation resulted in nothing. Immediately on making that inoculation I irritated the vesicle slightly with the point of the lancet, and obtained a small drop of clear fluid. With this I inoculated myself on the left arm. Aug. 23d, evening—Slight itching, with a little redness and thickening of the epidermis, over a space about one-eighth inch in diameter. Aug. 24th, morning—Itching has subsided. An elliptical vesicle, slightly irregular in outline on one side, has formed. Its long diameter is about three-sixteenths of an inch. It is only very slightly elevated, and the fluid lies beneath a very thin layer of epidermis—so thin as to undulate on drawing the finger lightly along over the skin at a short distance from the lesion. The vesicle seems to be unilocular. The centre shows only the effects of traumatism. Aug. 25th—The vesicle is now rather more than one-fourth inch long, and slightly less than that in breadth. It is of a dull red color, and raised even less than before. There is no induration and no itching. Aug. 26th—Nothing remains of the lesion except a dull redness, the contents of the vesicle having entirely disap-

peared. Aug. 27th—Redness remains. A small protuberant pustule has formed at one end of the red spot, on a portion of the surface previously occupied by the vesicle. I opened this pustule, and with the contents, which were opalescent, made an inoculation at a point about an inch distant. This inoculation proved a failure, as did also the following: Sept. 1st, inoculation from vesicle on thumb of Mrs. F. (Case 9), using an abundance of clear lymph; Sept. 10th, two inoculations—one from a small acuminated vesicle on the ankle of M. C. F. (Case 12), and the other, by Dr. Bulkley, from the vesicle on the wrist of G. E. M. (Case 10). The last two inoculations produced a minute tumefaction, which, however, disappeared within twenty-four hours. The red spot, which followed the successful inoculation, remained visible, but gradually fading, for about a fortnight.

As to the *cause* of this outbreak, I am unable to supply any positive information. None of the patients had, so far as I could ascertain, been thrown in company with persons bearing any similar eruption, or with persons recently vaccinated, and none of them had themselves been recently vaccinated. None of them had put on clothing which had formerly been worn by other persons, or by themselves while suffering from any eruptive disease. No skin disease was found on any of the domestic animals about the place.

The *nature* of the disease, as interpreted from its phenomena, seems to differ from that of all skin diseases of which I have any knowledge. The local physician called it "water-pock," which term, as we all know, is one of the synonyms of varicella. Its varicellous nature would seem to be disproved by its attacking those who had already had chicken-pox (Cases 9 and 11), by the entire absence of fever, and by the habitat and appearances of the eruption.

In some of its features the disease bears a great resemblance to the *impetigo contagiosa* of Fox—so much so that I was at first inclined to set it down as such, but it differs from that affection (as described by both Fox and Taylor) in so many and so important

particulars, that I have been led to reconsider my first conclusion. Like contagious impetigo, it is a vesicular disease, wholly local in its character, contagious, but not infectious, and attacking children by preference. The lesion, when well-marked, bears a strong resemblance to the vaccine pock, as does that of contagious impetigo. "Absence of pain and any itching of consequence save occasionally at the outset," is given by Fox as one of the features of contagious impetigo. With one exception (Case 9), this was true of my cases. The points of difference are as follows: *Herpes varioliformis* is wholly destitute of fever, either preceding or accompanying the eruption; whereas initial fever is a marked feature of contagious impetigo, although, as suggested by Dr. Taylor, it may be so slight as to be overlooked, except in infants. In four of my cases the eruption appeared in successive crops—papules, vesicles, and crusts all existing *at the same time* at the height of the disease, which is not the case in contagious impetigo. In the latter disease, the hairy scalp is a favorite seat of the eruption; but it was not affected in any of my cases. The most striking peculiarity of the lesion of contagious impetigo is, that it ends in a "flat, straw-colored, dry, granular" crust, which appears "as if stuck on." In my cases most of the lesions ended either in resolution or desquamation—the few which advanced to incrustation showing a thin, compact, more or less transparent crust. None of my cases were in any way connected with vaccination, which, as has often been observed, is a very common starting point of contagious impetigo.

My friend Dr. Taylor has called my attention to certain points of resemblance between my cases and the *vesicular hydroa* of Bazin (the *herpes iris* of Bateman), an affection which Bazin classes as a "pseudo-exanthematous arthritide."\* These points of resemblance attach mostly to the général appearance of the lesion, but they do not stand the test of close comparison. The distinctive feature of the lesion of vesicular hydroa is, that the circumferential *bourrelet*, which occurs rather frequently, is not, as in my cases, a true en-

\* *Leçons théoriques et cliniques sur les affections cutanées de nature arthritique et d'artreuse, etc.* Par le Docteur Bazin, Médecin de l'hôpital Saint Louis, etc. 2 me. éd. Paris, 1868, p. 194.

largement of the primary vesicle, taking place gradually, from day to day, but is formed rather suddenly, as a superadded lesion, and may be, after the lapse of a few days, surrounded by another vesicular circle, and the latter by a third — all of sudden formation, made up by the aggregation of small, originally distinct vesicles. The lesion progresses, then, by what may be termed *spurts*, and concentric shades of color occur, which have led to the affection being called *herpes iris*. Nothing at all resembling this process occurred in any of my cases. There are many other points of difference between vesicular hydroa and the disease which I have described, but the different course of the lesion is sufficiently distinctive.

I have, therefore, while very much averse to adding a new name to the already over-burdened nomenclature of skin diseases, felt constrained to do so in this instance, as I am unable to reconcile the features of the disease which came under my observation with those of any recognized affection of which I have any knowledge. The term *herpes contagiosus varioliformis* may not be altogether satisfactory, but it answers the purpose of present convenience.

I will simply add that this disease, although contagious, is probably not infectious; that it is productive of merely temporary discomfort and disfigurement; that its tendency to spread by contagion grows less as incrustation occurs; and that it tends to a rapid and spontaneous cure. Treatment, although not strictly necessary, is very efficient in controlling the extent and duration of the eruption, and in allaying the irritation to which the lesion sometimes gives rise. Tincture of iodine, applied twice a day, never failed in any of my cases, *when applied early*, to produce prompt resolution of the lesion. But its use should be confined to the stage of papulation. After vesiculation is apparent the treatment can be only palliative—chiefly the application of absorbent powders. The one which I used (simply because it happened to be at hand) consisted of calomel and oxide of zinc, each *one part*, starch, *two parts*.

## CLINICAL CONTRIBUTION TO SYPHILIDOLOGY.

BY DR. VAN BUREN AND KEYES.

THE two following cases came under observation within a few weeks of each other, at a recent date. Their study was to such a degree interesting, and the facts elicited at once so clear and so pregnant with suggestion, that it would seem allowable, instead of reporting them as isolated cases, to detail them briefly in conjunction; to call attention to their points of special clinical interest, and, perhaps, to deduce from them a few conclusions.

The clinical features of these cases are not new,—yet truth is always new—and such facts as these cannot be too often repeated, or dwelt upon with too much earnestness; they are being constantly denied, and they should be constantly upheld. Cases similar to the following are doubtless not very rare, their true nature often escaping the acuteness even of the expert observer—but still they are uncommon; the first, because the profession in this country is so much in accord on the early treatment of syphilis; the second, on account of the rarity of urethral chancre.

*Case 1.*—A gentleman from the north, a man of clear perceptions and excellent reasoning powers, of liberal education and skilled to observe—being himself a physician—related his case briefly as follows: While a student he got a small, insignificant primary sore. By advice of a medical friend he took no medicine. A slight papular rash appeared. For this he physicked himself with laxative medicine, but took no mercury in any shape. The rash disappeared in time, and was not followed by a successor. His health remained perfect. Nine years after the chancre a swelling appeared upon the cranium. This caused no uneasiness and was disregarded, in fact its nature not suspected, so entirely had nine years of health calmed the patient's apprehensions. The node remained, solid, hard, untreated, *for eleven years*, the general health continuing vigorous; but now the patient was prostrated, during several weeks, by a severe illness (having no relation to syphilis), and, on recovering from it, the node softened. It was opened as an abscess, but instead of healing, the edges sloughed extensively, leaving the bone bare over a circular area of more than two inches diameter. At the time of the patient's visit, the necrosis had been visible for nearly a year,

its nature had been suspected, but he had employed no specific treatment. The size of the sequestrum could not be determined, as it had not yet separated. Pus had burrowed extensively under the scalp for several inches posteriorly.

*Case 2.*—A gentleman living in the West acquired, as his first venereal malady, a slight urethral discharge. This proving obstinate to the simple measures employed, he finally worried his physician into giving him some strong injections of the nitrate of silver—with the result of laying him up with double epididymitis, and giving him a purulent urethritis, from which he slowly rallied. He cannot now be made to recall any other symptoms as having occurred at or succeeding this time (he is a gentleman of intelligence), and he is sure he took no mercury. In one year he married and had a healthy child. His wife never conceived again, but had no miscarriages and remained well. She is under the care of an expert in uterine diseases for malposition of the womb following her first confinement. Twelve years after this urethral chancre (as it probably was) some ecthymatous spots appear upon the patient's legs. He came to New York for their treatment and (suspecting their possible nature, since he had always been on the lookout for appearances of the enemy) consulted a specialist of distinction in venereal disease. The latter entertained the idea of possible syphilis (the patient states), but gave him a medicine to take in five drop doses, and to increase. This he used for three weeks until he had reached twenty drop doses, when he was obliged to cease on account of *red eyes and pain in his stomach* (arsenic).

The "boils," however, got well, and their sites are now occupied by round, smooth, thin, white, slightly depressed scars, still pigmented at the circumference, and entirely characteristic of an antecedent syphilitic lesion. One year later the patient ran down in general health, became yellow and thin, lost the power of reckoning, had hemi-crania and double vision, loss of memory, and many evidences of failing brain power. (Age, 47). His physician (in another city) told him that he was threatened with softening of the brain, and must give up work and go to Europe. This he did for a year, taking his physician with him. In Paris one of the most prominent specialists in nervous diseases in the world, in consultation with the doctor, agreed with him as to the impending softening, and told the patient his symptoms were due to threatened apoplexy. Hygiene and time removed most of his nervous symptoms, and he returned to America. After some months his present symptom developed; namely, tertiary gummy infiltration of the soft palate, with rapidly advancing destructive ulceration along the posterior border—for which he now applies for treatment—not in the least suspecting the nature of his disease. The diagno-

sis was not difficult, for nothing could be more characteristic than the appearance of the throat, and fluids already came through the nose on swallowing, the voice was defective, etc.

Improvement commenced at once and progressed with great rapidity under the iodide of potassium.

Here are two cases full of food for thought. The facts of the second case may be defectively stated, since the patient has had brain symptoms, and his memory may not be reliable. He doubtless may have had some eruption after his urethral chancre and not have noticed it or forgotten it, but still here are two individuals with infecting chancre, of whom the first (perhaps for fear of hurting himself)—certainly by design—the other through defective diagnosis, gets no mercury. The one has one mild eruption, the other nothing that he can remember—both are cases which, according to Diday, should get no mercury at all, yet see the terribly disastrous sequence in both—the one, after nine years, gets a node, which, after eleven years more, takes off the top of his skull—the other has brain symptoms and a threatened loss of the soft palate.

Yet even in these modern days, notably in Norway and Sweden, and Germany, but also in England, and somewhat in France and America, the opinion has many adherents, and certain authors boldly proclaim that mercury given early in syphilis is often (sometimes the word *always* has been used) the cause of the appearance of tertiary lesions, or at least of their being severe; the advocates of this theory forgetting the visceral lesions of inherited syphilis, where the mothers have not been treated, and ignoring cases like the above.

Again, in the foregoing cases, we have exemplified the not infrequent exception to the rule which lays it down that a mild beginning in syphilis portends a mild course for the whole disease.

Truly, had not No. 1 been prostrated by weeks of sickness, his node might not have softened, but still the node was there.

Further, the second case refutes the theory which states that iodide of potassium is only efficient after a previous use of mercury, for nothing could have acted more like a charm than did

this admirable drug in case No. 2. This latter case also touches upon the question of hereditary syphilis, going by just so much to confirm the theory that the father, no matter in what period of syphilis he may be, *not* poisoning his wife, has a healthy child.

Finally, how instructive are these cases as to the value of a careful and correct diagnosis. Had No. 1, himself a physician and in constant association with another medical gentleman, had the good fortune to have the nature of his node suspected during the eleven years of its existence before it softened, how promptly would treatment have quieted it and saved him from his present misfortune. And as for case 2, the comedy of errors of the distinguished physicians, whom he consulted on both sides the water, has become indeed a tragedy for him.

Although, then, both of these cases are exceptional, it is perfectly just to draw conclusions from them, conclusions which are not new deductions but ratifications of what has been long known.

These cases go far to strengthen the views that,

1. The evolution of syphilis may be mild and irregular, even where no mercury is used early in the disease.
2. With the mildest beginnings in syphilis (untreated), the most terrible consequences may occur after years of quiescence.
3. The severity of tertiary lesions does not depend upon previous use of mercury.
4. The efficacy of the iodide of potassium, properly employed, is not dependent upon a previous use of mercury.
5. A father with syphilis may have a perfectly healthy child.
6. Specialists and experts are liable to be deceived as to the significance of symptoms in a given case, and their authoritative position should call for the exercise of extreme caution in the expression of opinions, for their responsibility is great.

## SCLERITIS SYPHILITICA; ITS PATHOLOGY, COURSE AND TREATMENT.

BY FRED. R. STURGIS, M. D.

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THIS rare affection may, for convenience sake, be divided into three groups, viz.: Epi-or peri-scleritis, scleritis parenchymatosa, and scleritis gummosa, the main difference between the first two being that the former, epi-scleritis, is more limited and circumscribed than is the parenchymatous variety. The disease may occur alone, confined to the sclerotic and unattended by any complications of adjacent tissues; at other times it is associated with secondary changes in the cornea, the iris or in the ciliary body, when it becomes a matter of serious importance.

Primary lesions of the sclerotic are, so far as I am aware, unknown, the disease being usually associated with the stage of the so-called gummosous formations, when it commences as a limited point of redness situated near the edge of the cornea, over or close to the insertion of the external rectus muscle and forms a slight elevation, sometimes quite circumscribed, at others shading gradually off into the surrounding tissues. This elevation, which varies much in size, is, at its apex, of a deeper and more livid hue than elsewhere, is smooth in its appearance, and is covered, during its earlier course, with a sound conjunctival membrane. With all this apparent growth there is very little if any functional disturbance, it is not associated with pain, with photophobia or photopsia, nor is there much peripheral inflammation. Indeed, the symptoms of the disease are cold, insidious and slow, and its course is chronic. As it progresses one of two things may take place; ulceration or resolution. When the former occurs the apex only breaks down, while the sides of the tumor retain their translucent color; this may go on until the entire swelling is converted into an ulcer. Where resolution takes place the swelling slowly sub-

sides, becomes flattened, gradually loses its livid look, assumes a pinker hue, and finally disappears, occasionally leaving behind it a depressed, greyish or slaty discoloration to mark its former site. Ulcerations of these tumors fortunately are not common, the disease yielding to a vigorous and well-directed treatment. M. Flärer, in the "*Medizinische Jahrb. d. Oesterreicheschen Staates*," is accredited by M. Lagneau in his "*Maladies Syph. du Systeme Nerveux*," with the following history, which, to say the least, is very extraordinary, and a summary of which I give here more as a medical curiosity than any thing else.

OBS. 1. A young man, in 1830, contracted a chancre, which was followed, in due course of time, by alopecia of the head and face, by ulcerations of the palate, gummosus iritis and commencing amaurosis. In March, 1840 (ten years after the primary lesion), the following report is made of the condition of things in the left (the affected) eye: "The sight, and all perception of light, was lost, and outwards and upwards a tumor had formed in the sclerotic, the size of a hazel-nut. The swelling gave rise to an excavated callous ulcer, large enough to admit the end of the finger. Later, the tumor acquired the size of a fist,\* and became so painful as to deprive the patient of sleep. Under treatment with the decoction of Pollini,† the ulcer closed, the cornea became transparent again; but the globe of the eye had atrophied." G. LAGNEAU, fils, op. cit. P. 417.

When discussing the objective symptoms of the disease, I mentioned, among various others this sign, that there was not much peripheral inflammation, and it will be seen, in the case I am about to present, how very poorly marked this symptom sometimes is. Occasionally, however, it is much more prominent; but even then it is not nearly so marked as in a conjunctivitis or even an iritis. The notes of the case were taken from a patient, at the Manhattan Eye and Ear Hospital, and are briefly thus:

OBS. 2. W. S., æt. 26, denies all knowledge of the primary lesion, but admits that two years ago (1872) he had iritis of both eyes, more especially of R. and some alopecia. The present trouble began two months ago (Jan'y, 1874), without any pain, photophobia or

\* "Avait acquis le volume du poing."

† The principal ingredient is sulphuret of antimony in sarsaparilla; this "*tisane*" is not used in the U. S.

lachrymation, and presents the following symptoms: At the external border of the cornea, at lower edge of insertion of ex. rectus, beneath the conjunctiva bulbi, not adherent to this tissue, is a raised non-circumscribed tumor, seated apparently in the sclerotic, of a dusky red hue at the base and with a grey apex. Circumferential redness very slight and limited in extent. Conjunctival injection almost nothing. No pain, photophobia or lachrymation. The sclerotic vessels are red and enlarged. The tumor bears handling freely. There is at present no other affection of the eye. V.=1. Remains of old adhesions in R. E. None of L. No concomitant symptoms of syphilis elsewhere.

As a contrast to this case, in the severity of the objective symptoms, I will present another; for permission to use which I am indebted to Dr. R. H. Derby, of the N. Y. Eye Infirmary, whose patient he is.

OBS. 3. J. T., æt. 33, gives the following history: Primary lesion was contracted in 1871, and was followed at various dates by cutaneous eruptions on the body, cranial alopecia, rheumatoid and osteoscopic pains and hemi-crания. He says his present trouble began sometime in January, 1874. He was seen by Dr. Derby, for the first time, on March 10, 1874, who kindly wrote me out the following notes of the case: "Downwards and outwards, in the region between the external and inferior recti (left eye) was a new growth. The anterior portion of this neoplasm was about 4 " distant from the limbus, and by forced abduction of the eye (the patient at the same time looking upwards), its posterior portion was lost in the circumocular tissues. Over the tumor the conjunctiva was freely movable everywhere. The new growth presented a livid red color, could not be moved upon the eye, and was believed to spring from the sclerotic. It was exquisitely tender upon palpation. Over the region of the insertion of the lower rectus of this eye, and from this point to the region of insertion of the internal rectus, there was a dull bluish look (old scleritis?).

"The refracting media and fundus of this eye were normal. There had been circumorbital pain, and, as might have been expected, patient suffered especially whenever he attempted to look downwards and outwards to the left."

I saw the patient a month later in consultation with Dr. Derby, and the following condition of things was noted: Nocturnal hemi-crания of left side of head. Impairment of motion of left eye outward and downward. No photophobia. No pain in eye-ball. V.=1. About 4 " from edge of cornea, in the sclerotic, at the lower border of external rectus is a flat, livid swelling, very slightly raised

above the ball, surrounded and covered by a leash of vessels. No cyclitis. A pretty broad, riband-like strip of injected vessels sweeps along lower border of cornea to near the insertion of the internal rectus muscle.

There was no ulceration of the tumor, nor was there any swelling over the insertion of the internal rectus where the congestion stopped abruptly.

The iris was free from synœchia, nor was there any iritis or gummosous growths or exudation from the iris into the anterior chamber.

This case is one of interest in several ways. 1st. From the amount and peculiar shape of the congestion. 2d. From the absence of any complications, *i. e.*, iritis or cyclitis, and, 3d. From the lack of functional disturbance. There was no photophobia nor lachrymation, and his vision was normal. As compared with my own case (Obs. 2), there was more pain; but even this symptom was poorly marked; only in certain positions of the eye was it present, and then from constraint to the movements of the eye-ball.

As so few of these cases have been reported it will not be devoid of interest to review a very interesting case given by Estlander, of Helsingförs, in the *Klinische Monats-blätter für Augenheilkunde*, for 1870. It is headed "Gummy Tumor under the Conjunctiva bulbi," without any more precise definition; but, on carefully reading it over, it seems to me indubitably to have sprung from the sclerotic. The case is as follows:

OBS. 4. Helena Lagerblom, æt. 19, a servant from Tavastehus, came to my clinic July 5th, 1870. She stated that when two years old numerous persons in the house where she lived were affected with syphilis; among them her parents. At this time she also had a sore throat and mouth. About two years ago an ulcer formed on the left arm, below the olecranon; then a second came just above the internal condyle of the humerus, and finally a third one near the first. These ulcers, and the severe pain through the whole arm, induced the patient to come to the clinic.

At that time her condition was as follows: Appearance pale and anæmic, but well nourished; nothing abnormal in the internal organs; about the left elbow joint was an ulcer, whose irregular form and general appearance indicated that it was due to ulceration of syphilitic tubercles of the skin; below the right knee was a similar ulcer in process of healing, and several scars from similar ulcera-

tions. Nothing abnormal was seen in the eyes. Under treatment with iodide of potassium (first, gr. v, later, gr. x, three times daily) these ulcers began to heal.

On the 12th August the patient complained of pain in the left eye. On the outer border of the cornea, in front of the tendon of the external rectus, in the sub-conjunctival cellular tissue, there was a smooth flat tumor, which measured horizontally 6 mm., vertically 3 mm., and about 2 mm. high. Over the middle of the tumor, the conjunctiva was grayish white, as though commencing to ulcerate, but on the margin the epithelium was still present, and at this part the tumor was translucent. The conjunctiva, just around it, was red from injection, and from the conjunctival fold a couple of distended blood vessels advanced towards the tumor. The adjacent portion of cornea was grayish and opaque. As the tumor was divided with a cataract knife a slight quantity of purulent fluid oozed up, and a yellowish tissue, extending to the sclerotic, appeared in the incision. With the object of watching this tumor further, the eye was treated expectantly, while the iodide of potassium was continued internally. During the next five days, however, the inflammatory symptoms increased, so that inunction treatment was resorted to. Until the 3d September, a half drachm of *Ung. Hydrarg.* was rubbed in daily, but then it had to be discontinued as the mouth was affected. From the commencement of this treatment the inflammatory symptoms began to subside, as did the tumor itself, and a week after the termination of the treatment only a deep grayish cicatrix was left. Of the opacity of the cornea only a fine line on the outer border remained.\*

In this as well as in my other observations, cases No. 2 and 3, the tumor was circumscribed, and the inflammation localized in extent. One point, however, is noteworthy; the pain is much more marked here than in the other cases, perhaps due to her anæmia; this symptom of pain is not common; indeed, in syphilitic affections of the eye, the absence of this symptom is noteworthy, in contradistinction to those not due to specific causes.

Beside the pain, complications existed in the shape of ulceration of the conjunctival mucous membrane and opacity of the cornea. In the beginning of this paper, I spoke of the iris, conjunctiva, and even the cornea, sometimes participating in the disease, and this is not surprising when we reflect upon the intimate relations

\* Translated by C. E. Hackley, M. D., in the Am. Journal of Syph. and Derm., April, 1871, p. 155.

which exist between the various structures of the eye; on the contrary, it is a wonder how the deeper portions ever escape.

The two next histories which I give are quoted from Barbar's Inaugural Dissertation, "*Ueber einige seltene syphilitische Erkrankungen des Auges*," Zurich, 1873, and present a beautiful picture of this rare and interesting affection.

OBS. 5. The first case is that of a man, æt. 26, who had previous to his scleritis twice entered the ophthalmological clinic of Prof. Horner, at Zurich, for gumma iridis, associated with a syphilitic eruption of the skin. The syphilis dated back certainly one year and four months, perhaps longer, as the date of the primary lesion could not be ascertained, although on his first admission to the hospital it is mentioned that there was "a hard, somewhat elevated spot upon the glans penis."

An interval of nearly five months had elapsed between his second and third entrance into hospital, which was on February 3d, 1871. Here is Barbar's account of the case:

"His left eye had been attacked afresh. Two millim., from the upper and outer edge of the cornea, and covered over by the conjunctiva, was a reddish-yellow tumor, almost as large as a cherry stone. It is resistant; its contour is sharply defined; it pushes the sclerotic, with which, on its inner surface, it is connected, forward, while the conjunctiva, both at the sides and apex, is freely movable. Both the conjunctiva and the sclerotic are injected in the neighborhood of the swelling, and the adjacent portion of cornea is the seat of a slightly diffuse opacity. The tumor gives rise to no spontaneous pain, but patient reports a dull ache, if pressure be made over it. From his previous history, and for reasons which are presently to be given when discussing the differential diagnosis, there was no question of its being a gumma of the sclerotic.

The local treatment merely consisted in the instillation of atropine.

Internally, the iodide of potassium was renewed. Under this treatment the tumor gradually diminished in size, and at the same time the injection slowly disappeared. Without any change in the tension of the globe, the seat of the swelling became gradually transformed into a thin, bluish transparent depression.

OBS. 6. Was an anæmic woman, æt. 33, who came under observation the end of March, 1872. "The right eye had been painful for about fourteen days, and she thought there was a foreign body in it. Examination showed a decided injection of the ciliary region, an opaque cornea, pupil firmly bound down by synechiæ, discoloration of the iris; in short, the picture of a severe iritis. The history was extremely defective, the date of infection could not be obtained

with certainty, but the pharynx was very much congested, the tonsils were swollen, and the cervical lymphatics were infiltrated, in some places suppurating. The iritis progressed with extraordinary rapidity, the iris became more opaque without any pain, and the pupil was blocked up with a tough, purulent, fibrinous exudation.

On April 8th, an elevated point of redness on the sclerotic was noticed about 2 mm. from the edge of the cornea. It was resistant, perfectly circular and sharply defined. The injection of the conjunctiva was marked. An inflammation of the right knee-joint led to a thorough examination of the patient, when, for the first time, a skin affection was noticed, which, up to that time, had been concealed by the patient. This upon the arms and upon the thighs had a most characteristic appearance, consisting of small vesicles with clear contents and red base, larger pustules filled with pus, and more extended base and finally of circular crusts 1-1.5 cm. broad, surrounded with a red areola. These last, according to the patient, were of three weeks' duration. The inguinal glands were markedly indurated, the congestion of the pharynx had increased, and its mucous membrane showed in places a decidedly lardaceous appearance.

\* \* \* \* \*

Under mercurial treatment the eye quickly improved, the absorption of the purulent exudation taking place with unusual rapidity. The scleral swelling entirely subsided, leaving behind it a very decided greyish cicatrix, which when last seen (June, 1872) had become entirely white. The synechiaæ were slight and only a few floating bodies were left in the vitreous. As the constitutional symptoms were severe and obstinate, the patient was transferred to the venereal division of the hospital towards the end of April.

\* \* \* \* \*

The patient died in October, 1872, of typhus, and at the autopsy the characteristic syphilitic atrophy of the liver was observed."

In these two cases, we notice, much the same train of symptoms are noticed as in my own cases, viz.: the circumscribed character of the swelling, the absence of severe pain or extensive inflammation, and the cold, insidious course of the disease.

The time at which this symptom appears it is hard to state absolutely, judging from these six cases; we may say in a general way that it is one of the late manifestations of syphilis, occurring from two to four years after infection, even later, perhaps. In Obs. 1, it appeared two years after the primary lesion; in Obs. 2, how much more than two years after it is impossible to say, but certainly more; in Obs. 3, about three years after the initial lesion;

in Obs. 4, fifteen years (?); in Obs. 5, sixteen months, probably longer; and in Obs. 6, no time could be assigned from a defective history.

I have gone thus fully into the description of these gummata of the sclerotic because of their rarity; but before concluding let me say a few words upon the two other varieties of the disease.

As I have already said both epi-scleritis and scleritis parenchymatosa, unassociated with gummous formations are very rare. Their existence is mentioned, but as I have never seen any cases, I cannot speak of them from personal knowledge.

Broadly speaking, *S. parenchymatosa* is a more diffuse form of epi-scleritis and, as the name denotes, has its seat in the interstitial layer of the sclera, in the same manner as the form we have just been describing; with this difference that instead of remaining localized it shows a tendency to become diffuse.

The various stages through which it goes are as follows:

1. Vascularity of the sclerotic, which at first circumscribed afterward becomes extended and irregular.

2. A slight salience of the tunic at this point; this however may readily escape notice as it is sometimes slight.

3. An increase in the appearance of the redness, which becomes almost purple; this changes later to a grayish color and slowly disappears to give place either to the normal condition or, what often occurs, a thinning of the sclerotic itself. There is but little pain associated with this affection and only during exacerbations, is there lachrymation. Photophobia is also absent, save in those cases where iritis, keratitis or choroiditis co-exist with the scleritis.

The treatment in these cases is two-fold, constitutional and local, nor is one less important than the other. The local treatment consists in the instillation of a solution of atropine (gr. ii., iv, to Aq. 3 i.) twice or thrice daily, or until the pupil is fully dilated and this with a double object, to prevent synechiæ, should iritis supervene, or to break them up if they already exist, and to relieve the engorgement of the vessels. Applications of ice, leeches or warm water will only be necessary should severe in-

flammatory symptoms set in from participation of the iris, the cornea or the ciliary body in the disease.

The constitutional treatment is such as would be used for the relief of other syphilitic lesions; mercury alone or in combination with the iodide of potassium. But let me say that excellent as is the iodide of potassium in the treatment of syphilis, we must not rely too much upon it to the exclusion of mercury, which after all is the surer and more trustworthy agent.

Perhaps the best way of using it is by inunction in drachm doses to the soles of alternate feet every night, as long as the patient will tolerate it or until the disease yields. During the treatment bid the patient wear the same stockings night and day. But of course we must not be wedded to any one form of treatment, but be ready to adopt any method, external or internal, which our own sense of fitness may suggest or which the case may seem to require.

NEW YORK, *October, 1874.*

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## THE COMPOUND MICROSCOPE AS AN AID TO THE STUDY OF THE SKIN AND SKIN LESIONS *IN SITU.*

BY HENRY G. PIFFARD, M. D.

*Clinical Professor of Dermatology in the Medical Department of the University of the city of New York, etc.*

THE difficulties and inconveniences which surround the attempt to study the integumentary surface with the aid of the single lens or simple microscope are of such a character as absolutely to preclude the employment of lenses of high power. These difficulties are mainly the following: The shorter the focus of the lens employed the nearer it must approach the object, and consequently the amount of light that can be thrown upon the object is diminished, the field of view becomes contracted, and the spherical aberration becomes so evident as to materially jeopardize the

accuracy of the result. I do not deny the possibility of obtaining a simple lens free from this form of aberration, as I possess one made by Steinheil, of Munich, which is admirably corrected in this respect, but the great majority of simple lenses are uncorrected, and consequently give distorted images of the objects under examination. In addition, the shorter the focus of the lens, the nearer must the eye of the observer be approached. This often involves a constrained position of the head and neck, tiresome to the observer, to say nothing of the unpleasantness of too close contact in some cases.

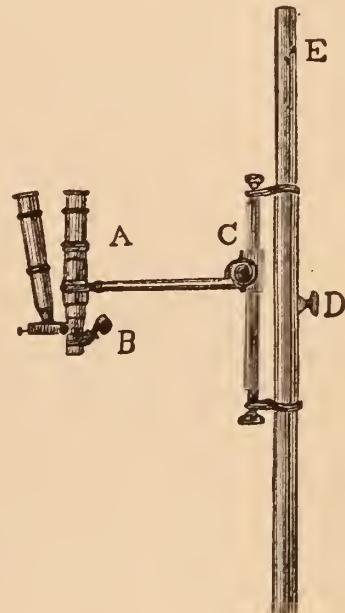
To obviate these inconveniences and at the same time to obtain a comparatively high amplifying power became then a problem worthy an attempt at solution.

After much fruitless experimentation I arrived at the apparatus shown in the accompanying figure.

*A* represents the body of a binocular microscope made by Nachet, from which the reflecting prism, situated above the objective, was removed, and another of the same form but double the size substituted. *B* is a double nose piece carrying two objectives of different powers. *C* is the pinion for fine adjustment, and *D* the clamping screw for coarse adjustment. *E* is a rod five feet in length which supports the other apparatus, and is itself supported by a cast iron foot, not shown in the drawing. Other adjustments permit the body of the microscope to be placed in a horizontal or any other desired position.

The objectives which I employ are a 6", 2" and 1" of Grunow, a 4" and  $\frac{1}{2}"$  of Ross. The  $\frac{1}{2}"$  is made with taper front, specially constructed for use with reflected light.

The advantages of this arrangement over the single lens, are enlargement of the field of view, absence of spherical and chro-



matic aberrations, convenient distance of the observer's eye from the object observed, ten times the amplification practically attainable with the simple microscope, and lastly the very great advantage of true stereoscopic vision.

With the instrument described any portion of the integument from the scalp to the sole of the foot can be conveniently examined, and a prolonged examination can be made without fatigue to the observer.

The ordinary diffused light of a bright day affords ample illumination with all the objectives except the  $\frac{1}{2}''$ . For this we need direct sunlight. If the examination be made at night or in a dark place, the light from a Tobold or other good illuminator, concentrated upon the object with a mirror or bulls-eye condenser, will answer every purpose.

It is not my intention now to enter into the results of observations made with this instrument, but simply to suggest its use to those who desire a fuller acquaintance with surface aspect of the skin, or of skin lesions observed *in situ*.

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## ON THE EMPLOYMENT OF WAXED TISSUE PAPER AS A LOCAL DRESSING IN SKIN AFFECTIONS.

BY DYCE DUCKWORTH, M. D., EDIN.

*Fellow of the Royal College of Physicians, London; Assistant Physician to St. Bartholomew's Hospital, and Demonstrator of Skin Diseases.*

**I**N this short communication I propose to call attention to a plan of local medication which I have found very useful in certain skin-diseases.

All practitioners must have found it difficult sometimes to secure comfortable and efficacious dressings for localized patches of eczema and such affections as entail loss of the epidermis.

If lint is employed, as is usually the case, and some ointment,

such as *ung. zinci*, be smeared upon this, a certain amount of bandaging is rendered necessary to secure this in its place.

I have found that in many situations the lint and bandaging may be dispensed with, and in its stead a piece of waxed tissue paper proves eminently serviceable.

This material is kept by pharmacists, who cover gallipots, etc., with it, and it consists simply of thin tissue paper dipped in melted wax. A piece of this is to be cut of a size sufficient to extend beyond the margins of the sore place, and the ointment suitable to the case is to be smeared upon it. The paper is then applied to the affected surface and adapted carefully to the part. Care must be taken not to put on too much ointment, or there will be a tendency of the paper to move from its position, and the excess will also exude at the edge.

It will be found that this simple plan of dressing will obviate, in many instances, the necessity for bandaging. I have often been astonished at the adhesive properties of this paper. It is especially useful for patches of eczema, herpes, pemphigus and for superficial injuries.

I have adopted waxed paper also in cases of extensive eczema of the limbs instead of lint, and have applied a light bandage over it. It has the advantage of being cooler, and in hospital practice it possesses also the merit of cheapness, so that poor patients may carry away a supply with them. The dressing may be left untouched for twenty-four or even forty-eight hours. If it be left for a longer period it is apt to stick unpleasantly to the skin. When the paper is simply laid on an eczematous surface without further dressing, it need not be changed oftener than twice in the twenty-four hours.

## LICHEN RUBER (PLANUS.)

LETTER FROM DR. KAPOSI OF VIENNA.

*To the Editor Archives of Dermatology:*

DEAR SIR:—When I read the first of the cases of Lichen Planus so accurately and ably described by Dr. Taylor in the October number of the "Archives," I was impressed with the fact that it was a case of the *lichen ruber* of Hebra, and I was, therefore, the more agreeably surprised to find at the end of the very interesting article (page 38) that the writer himself expressed the same opinion.

These cases certainly have but little resemblance to the cases of lichen ruber observed by Hebra in earlier years, and from which the still excellent description of the disease was made in the first edition of his work (page 315). But since that time we have noted another form of the disease which appears either more localized (as on the arms, legs, labia majora, also on the loins and thighs, these latter observed alone by myself), or of very universal extent. These newer observations I have, in conjunction with Prof. Hebra, given expression to in the recently published second edition of his work. On page 389 we find: "The papules of lichen ruber are of two kinds. In some cases they are of a light-red or a brownish-red color, conical, very compact, and covered with a dry, white, firmly adhering scale, giving a very rough sensation. When the flat of the hand is passed over these spots the feeling, and also the sound produced, is similar to that made by passing the hand over a nutmeg-grater.

"In other cases the papules are quite as generally distributed, and uniformly of the size of a millet seed, but they are pale red, of a waxy appearance, smooth on the surface, rounded on the top (that is not conical), and have on their summit a very small but clearly-defined depression." Further on we read, "Sometimes newly-developed papules appear closely packed around an old

papule, in a circinate form. The centre of the patch sinks in, disappears and leaves behind it an integument marked by atrophied depressions, generally also darkly pigmented or traversed by dilated blood-vessels. Thus there are formed patches from the size of lentil to that of a silver dollar, whose periphery is formed of one or several circles of the above-described waxy, shining, depressed papules, as a broche with a border of pearls, while the centre is evenly depressed, or in addition appears marked with slight hollows and is darkly pigmented.

"In most cases the first-mentioned method of extension of the disease," (*i. e.* by the irregular development of new papules in such a manner as ultimately to form large patches of evenly diseased surface.—ED.) "is found, the latter form occurring more rarely; sometimes both forms of development are seen in the same person, when the aggregated and circinate *plaques* are found as a rule on the extremities, and the irregular and diffused patches mostly on the trunk."

With reference to the resemblance to the papular syphilide and *condylomata lata*, I have spoken under the head of Diagnosis (page 392, Hebra, 2d edit.).

All these elements agree so completely with those given by Dr. Taylor, that I believe we can assume that we both have quite the same disease under observation, and, moreover, there is no doubt but that the disease is the one designated by me as lichen ruber, for in some cases both forms are seen together. Dr. Taylor's cases, therefore, are the same affection, although the disease was localized; furthermore, I myself have also seen it thus confined to certain parts.

As to the *depression*, it corresponds, as microscopic examination shows, to the position of several papillæ, and BIESIADECKI thinks, from his own and also from my preparations, that the spot of atrophy is always in the neighborhood of a hair, and indeed, that it corresponds to the place of insertion of the *arrector pili* in the upper part of the corium. (Untersuchungen aus dem pathol. anatom. Institute in Krakau. Wein, 1872, page 33, fig. 6.)

What appears most surprising to me in Dr. Taylor's communication is the effect of the treatment employed. In the form of lichen ruber in question, as soon as the disease became at all general, or when a patient appeared with the ordinary form, we have always made use of the continued internal administration of arsenic, and have seen it in every instance followed by a cure. Whether, with a limited development of the depressed form, local remedies would not suffice with us, whether, indeed, in certain instances this form may not remain localized, I cannot at present say, although I have, from observations already made, some foundation for such an opinion, but I consider the material too insignificant to permit me to give any expression of opinion in this direction. With assurances of high esteem, believe me,

Very truly yours,

DR. KAPOSI.

[Remarks by the EDITOR.]

It is with much pleasure that we have, though hastily, translated the preceding letter from Dr. Kaposi, as many important points are brought out thereby, and a striking opportunity is afforded us of comparing dermatological observations here and in other lands. Not the least advantage is the friendly exchange of opinions which the matter affords, which we trust may be indulged in on many occasions by our colleagues in other lands, Dr. Kaposi, also expressing the hope, in a former part of the same letter, "that the ARCHIVES OF DERMATOLOGY may be an active means of communication between dermatologists of different lands."

Let us then briefly consider:—

1. The identity of the diseases described in Germany as *lichen ruber*, and in England and America as *lichen planus*.
2. The nomenclature employed.
3. The results of treatment.

*First.* That the disease described so ably in our last issue by Dr. Taylor is the same as the one alluded to by Dr. Kaposi, there is no doubt in our own mind, after carefully going over the entire article in the second edition of Hebra, 1874. We had, moreover,

personal opportunity of observing some of Dr. Kaposi's cases, several years since, in Vienna, as well as some of those of Dr. Taylor, and can confirm the descriptions, and would further illustrate the subject by the following case which has very recently come under treatment :

Mrs. A. M., aged 35, has generally enjoyed good health, although never very strong, has never had any former eruption, but has had rheumatism, as also some family history of the same. Her mother, a well-preserved old lady of 73 years, has the whole of the neck, ears, and a part of the scalp, involved in pityriasis rubra, which has lasted many years. Our patient gives the following history :

Eight years ago she noticed a patch of red, hard skin beneath the right arm near the axilla, which has remained much in its original condition until two or three months ago, when she noticed it spreading down on the right arm. Very shortly afterward the same affection appeared about the left axilla and extended thence upon the left arm, appearing upon the left thigh about the same time and then on the right thigh. The progress of the disease has been rapid during the last two months, new patches have developed continually, and the original ones have increased rapidly in size. When first seen the eruption occupied the parts mentioned, to a greater or less degree, namely : both axillæ and upper and lower extremities, there being none at all on the body. On the arms the disease occupies chiefly the outer aspect, the patches being irregular in shape, covering, perhaps, one-third of the surface. On the forearms the eruption is in scattered spots, mostly circular, varying from one-fourth to one inch in diameter. On the thighs and legs the patches are of medium size, more or less circular in shape, and extending down on to the left foot, where there are several patches on the dorsal surface, and quite a number extending around the inner aspect to the sole of the foot. Here they are of a darker color, and have more scales than elsewhere.

The characters of all portions of the eruption are the same, to wit : a slightly elevated surface of purplish hue, with a small amount of quite adherent scales. The patches are evidently made up of separate papules fused together, as is more particularly distinguishable at the edges. The borders of each patch are sharply cut, and stand out from the adjoining healthy skin to the height of from one-fourth to one-half a line. The surface is not really cracked, but is marked in lines corresponding in a measure to the normal epidermal lines, the surface of the patches is perfectly flat, and the upper edge turns pretty abruptly, that is, the papules are not conical, but the sides of the patches are at nearly right angles to the

skin. On the surface there is a small amount of hard epidermal covering, not readily detached, and of a shiny, pearl-like lustre. On some of the patches, which are fading, on the legs, there is a staining of the skin in the centre, but little if any thickening, nor is the thickening of the patches very great, hardly double the normal skin, as Kaposi has noticed. Nor can the depression on the summits of the papules be observed, which has been particularly noticed by Wilson, Hebra and Taylor.

The eruption itches and burns considerably, and is developing pretty rapidly.

A careful study of the descriptions of Wilson and Fox renders it very clear to us that the disease in England, Germany, and America is one and the same, presenting the same characteristics, with the exception that the general or widely diffused form of the disease is comparatively rare in England, while we are not aware of its having been observed in this country, having never met with it, either in private or public practice. The difference must be attributed to influences inherent in the nation, country, etc., for we know that lupus reaches a degree of severity in Vienna seldom if ever attained here, and as the study of dermatology advances in America other differences and peculiarities in special diseases, will undoubtedly be observed.

We are satisfied, however, that the disease we have been studying, lichen planus or ruber has an identity of its own as truly as have eczema and psoriasis, and the diagnostic differences between it and other eruptions liable to be mistaken for it, are given most admirably in a tabular form by Hebra; space forbids our quoting them here.

The disease is by no means common; in the first edition of Hebra's work, the number he had seen was stated at 14, in the second edition, fourteen years later, the number is given at something over 50. Wilson mentions 50 cases of lichen planus in 10,000 of miscellaneous skin diseases; Anderson records but one case of lichen ruber in 11,000 cases, and that one was among the 1,000 cases of private practice; Fox mentions having seen a number of cases, not stating the number. According to Hebra, one-third of those attacked were females, although there was but one

female among the 14 cases spoken of in his first edition; with Wilson there were 27 females to 23 males.

Second, as to the *nomenclature* of the disease. If it is to be admitted into dermatological classification, as it certainly must be, it is very necessary that it should be rightly named, and that but one name should be employed.

As is known, Hebra rejects the term lichen, as applied by Willan and many of his followers to a more or less diffuse eruption of acutely inflamed itching papules, all such eruptions, as they appear to him, being classed as eczema, he limiting the term lichen to two forms of disease, attacking a large portion of the body, namely, lichen scrofulosorum and lichen ruber.

Whatever may appear clinically true in Vienna, it is equally true, that there exists with us a papular disease which presents characteristics different from eczema, on the one hand, and from Hebra's lichen on the other, and yet which is properly called lichen from the character of its lesion, following Willan, Wilson, Fox, and many other writers, all, indeed, except the Vienna school. This is briefly described as an eruption of discrete papules, hard, acuminate, never developing into vesicles, nor coalescing into the patches of the lichen planus in question. For American dermatology, therefore, we are constrained to recognize the *lichen simplex* of authors, and with Fox make three forms of lichen, namely: lichen simplex, *lichen ruber planus*, and lichen scrofulosorum. It will be noticed that we have united the terms ruber and planus, which appears advisable, inasmuch as two such authorities as Hebra and Wilson have each given a name, and, as both can properly be used, we may avoid confusion by employing both,—*i. e.*, the *ruber* to indicate the red condition, as distinguished from the "pale, yellowish-red papules" of lichen scrofulosorum, while the term *planus* well indicates the level surface of the aggregated papules as well as the flat character of the separate papules, as distinguished from the acuminate papules of lichen simplex, which might from their red color be

equally well styled *lichen ruber simplex* in contradistinction to those of the *lichen scrofulosorum*.

*Third.* As to the *treatment* of the affection in question, Dr. Kaposi has expressed surprise at the results obtained in Dr. Taylor's cases, and mentioned that he relied on arsenic. On referring to the second edition of Hebra we find that it is only by very long continuance of very large doses that any beneficial result was obtained, that is, after from six to eighteen months, and when even several drachms of arsenious acid had been taken.

This we think a very important and instructive point, and one which cannot be too strongly dwelt on, namely, that while arsenic is valuable when used protractedly, there are other means which will relieve many cutaneous affections much more rapidly, as is shown in Dr. Taylor's cases, and as is learned from what has been written by Wilson and Fox, and by daily experience. *Lichen ruber planus* is perhaps, more than most of other skin affections, a congestive disease, as Hebra states that very few traces of the lesion can be found after death, however red and thickened the patches during life, on the cadaver they are pale, lax and not at all thickened, and but a few traces of adherent scales are seen. The indication then would be to relieve the cutaneous congestion during life, and this was done in Dr. Taylor's cases by an alkaline and diuretic treatment, and the outward use of warm alkaline and bran baths, followed by a moderate stimulation with the compound tincture of tar and green soap, and the results were most satisfactory, as also in the above case.

That arsenic will in time affect the cutaneous circulation and restore tone to weakened capillaries there is no doubt, but that this and many other congestive skin diseases, are best relieved by other measures, is equally or rather, more clear to our mind. While also external stimulation is valuable in cutaneous therapeusis, there is likewise no doubt that measures calculated to soothe are advantageous when the former will fail, as witness Hebra's statement that "no local means can affect any essential change in the course of *lichen ruber*," the means used in Vienna being largely stimulating.

## Clinical Reports.

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### I.—*Cases illustrating some of the Disorders of the Nervous System produced by Syphilis.* By E. C. SEGUIN, M. D., New York.

I OFFER to the readers of this journal the following cases of epilepsy and paralysis, produced, apparently, by the action of syphilis upon the brain and spinal cord, as a very small contribution to a subject which is daily assuming greater importance in the minds of those who make a special study of nervous diseases. I am aware that these cases will serve only to illustrate the symptomatology of the affections, and reserve the right of using them at a future time for a more exhaustive study of the matter.

#### SYPHILITIC EPILEPSY.

*Case 1.*—An adult male, a patient of Dr. W. H. Draper, contracted a chancre from a woman who, upon examination by Dr. D., bore no lesion, either recent or old, upon the sexual organs. At time of taking these notes she had presented no secondary lesions. In due time this gentleman exhibited syphilitic psoriasis and a moderate display of mucous patches; no tertiary manifestations. There was much impairment of the digestive functions, with frequent diarrhoea during the summer, and the iodide of potassium was not over well borne. In September of the same year (1873), while sitting in his office, when quite as well as usual, he felt a queer sensation in the region of the right deltoid (numbness), which very quickly ran down into whole of arm and hand. He had same sensation in right side of face, with almost simultaneous tonic spasm throughout the right side, body and face. Speech was much embarrassed for a few moments. A very intimate friend's name being mentioned, he asked, "B., Who is B?" showing marked amnesia. Pt. asserts that he did not lose consciousness. There had been no second attack. Dr. Bumstead, who saw the patient in consultation, expressed the opinion that this epileptiform seizure was different from attacks observed in the tertiary period of syphilis, and advised the use of mercury by inunction. The patient has remained free from any further manifestations of disease.

*Case 2.*—A gentleman, aged forty-three, a patient of Dr. Brown-Séquard, seen by me in January, 1872, in 1857-8 had primary and secondary syphilitic symptoms in Russia, for which he was thoroughly treated during a period of three years. He remained well until 1870; living pretty high all that time, though not drinking to intoxication. On the 4th of July, 1870, he was seized, during the night, with a severe epileptic paroxysm, lasting several hours (?). Came out of it without paralysis. He at once came to town and submitted to treatment by large doses of iodide of potassium. During the summer and autumn of that year, he had some four attacks, the last occurring in the middle of October. He never had diplopia. In March, 1871, he consulted Dr. Brown-Séquard, and was by him put upon the use of the iodide and bromide of potassium. According to the patient's statement, he was then in a state of great debility, and was much weaker upon the left side of the body than on the right, and suffered from marked impairment of memory. In these seizures there was no preceding aura; he was as if struck down. Up to date, January, 1872, has had no return of symptoms; has much improved in general health.

It is worthy of remark that in both these patients the epileptic manifestations occurred before the tertiary period of the syphilitic infections, and that in both a cure was obtained by the use of mercury, the iodide and bromide of potassium.

#### CASES OF PARALYSIS.

*Case 3.*—A middle-aged male, observed at the New York Hospital, in 1866. Had primary syphilitic sore in 1856, accompanied by non-suppurating buboes. Within the next half-year had marked skin symptoms, and repeated attacks of rheumatism, not articular, from 1858 to 1861. In 1861 had diplopia lasting six months; in 1862 a bad sore-throat. Was apparently well after this until November, 1865, when he began to suffer from severe frontal headache, and had occasional double vision. The head pain was much worse at night; he had frequent frightful dreams, and decided loss of memory. In the spring of 1866 there were attacks of vomiting on rising in the morning, and once or twice during the day; he had more or less vertigo, more headache, and greater loss of memory. Later, the vertigo increased so much that walking was possible only with the help of a stick; and even with it he staggered greatly. About a month before admission a hard swelling appeared upon the forehead; and difficulty in articulation showed itself. Has been absolutely impotent since spring, some five months. On admission walks with a peculiar staggering gait, which is neither the dragging step of paralysis, nor the jerking step of ataxia, but a tottering;

standing with eyes closed is impossible. On the central part of forehead is a node as large as a silver dollar, somewhat painful. Internal strabismus of right eye, and double vision; no ptosis; sight sharp. Vomiting is apt to occur whenever patient rises from the recumbent posture; never when he lies quiet. The only paralysis to be found is that affecting the right abductor muscle of the eye.

Under the persistent use of iodide of potassium this patient ultimately recovered perfectly from all symptoms except the strabismus.

*Case 4.—Paraplegia.* J. R., aged 42, of intemperate habits, and admitting great sexual excesses, in 1864 had primary sore and secondary syphilitic symptoms. During the fall of 1869 he suffered from pain in the right side, and, later, in the back; this being made worse by motion. March 6, 1870, he awoke with both legs numb, and retention of urine. Admitted into the Epileptic and Paralytic Hospital on Blackwell's Island, bearing a large bed-sore on sacrum, and having a paraplegia characterized by numbness and excessive reflex action. He reports that before admission he could not move limbs in the least. Improvement began in July; noticed sensation of distended bladder, acquired some voluntary movement in both legs; more control over left. Unable to control rectum or bladder. Improved much under hypodermic injections of strychnia; bed-sore healing. During 1871-2 took iodide of potassium in large doses. I was disposed to consider the paraplegia as one dependent upon a syphilitic lesion of the spinal dura mater. There is a large node upon the right tibia. Sensibility of lower limbs is almost normal; reflex movements are excessive; there is no loss of power in the lower extremities, the paraplegia being of the form I have designated tetanoid pseudo-paraplegia.\* In January, 1873, presents the same grouping of symptoms, though in a much less marked degree; very great improvement having been obtained by the exhibition of large doses of iodide of potassium, and the occasional giving of mercury. At the present time, November, 1874, this patient suffers from such great reflex action during attempts to use his legs, that tetanoid pseudo-paraplegia still exists.

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II.—*Cases illustrating the treatment by Electrolysis.* By FRANK P. KINNICUTT, M. D., New York.

The following cases, occurring recently, illustrate well the electrolytic action of the galvanic current in certain skin lesions:

*Case 1.* From Dr. Seguin's clinic.—E. S., aged twelve, *cavernous tumor of right cheek*, size of hazel-nut, with circumscribed connective

\* See on Tetanoid Pseudo-Paraplegia, Brown-Séguard's Archives of Sci. and Pract. Med., I., p. 101 (1873).

tissue induration. Patient being anæsthetized, the tumor was subjected to electrolytic current from twelve cells of Stöhrer's battery for three minutes. *No pain* followed the operation, nor was there any blood lost. Two weeks later the wound had healed, with almost complete disappearance of the tumor. A second application was followed by cure; a small cicatrix only remaining.

*Case 2.* From Dr. Seguin's clinic.—W. N., three æt., *nævus of right cheek*, size of large pea, with marked induration of neighboring connective tissue. Patient was anæsthetized and a single needle, connected with the negative pole of twelve cells of the same battery, was introduced into the tumor. The current was allowed to pass for three minutes. *No pain* or *hæmorrhage* followed operation. Two weeks later, a second similar application was made, followed by complete cure, scarcely a visible cicatrix remaining.

*Case 3.* From Dr. Seguin's private practice.—M. A., twenty-five years of age, *vascular tumor of lower lip*, size of hazel-nut; dating from childhood. Cure after four applications of electrolytic current; twelve cells used. *No pain* following the operations, and only very slight hæmorrhage.

*Case 4.* From Dr. Draper's private practice.—Miss N., thirty æt., *follicular tumor of upper lip*, size of pea. The patient was not anæsthetized. A single needle, connected with six cells of a battery, was introduced into tumor. Little pain was felt during the operation; none at all afterwards. Not a drop of blood escaped on withdrawing the needle. A cure was effected after three applications; unnoticeable cicatrix remaining.

The simplicity of the operation, the subsequent absence of pain or other discomfort, the avoidance of hæmorrhage and disfigurement, together with the thoroughness of the cure, are the points of interest illustrated by the above cases. A comparison of the *alterative* action of the electrolytic current with that of the various escharotics, will be illustrated by a number of cases in a future number of this journal.

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III.—*Molluscum Sebaceum.* By WALTER G. SMITH, M. D.,  
Assistant Physician to the Adelaide Hospital, Dublin.

This curious and clearly-defined affection, although tolerably common in an isolated form and in a minor degree, is yet sufficiently uncommon in a multiple or exaggerated form to render worth noting any special cases of it. Among 1,100 hospital patients I observed it four times, and M'Call Anderson, in 10,000

hospital cases, met with but six examples of it, and none at all among 1,000 cases from private practice. Although its comparative rarity could not be inferred from hospital statistics alone, for, since it seldom gives rise to any annoyance, the poorer classes are apt to disregard it, yet its absence from Dr. Anderson's private statistics proves its real infrequency. It so often occurs about the face, that in the higher ranks of society medical advice would certainly be resorted to.

In November, 1873, a young girl, aged six, was brought by her mother to the Dispensary for Diseases of the Skin at the Adelaide Hospital, on account of some small, button-like tumors which had come out on the upper part of the trunk. The eruption appeared about seven months previously. The first speck came out on the back of the left shoulder, and others then sprang up in the neighborhood. When first seen there were eighteen or twenty of these little tumors scattered about the shoulders, usually quite separate except in one place where two cohered, but preserved their individual form. They were on the average about the size of a split pea, were sharply circular, white, sessile or slightly constricted at the base, and presented at the summit the characteristic umbilical depression and central aperture from which sebaceous matter could be expressed. Some of the tumors were touched with nitrate of mercury and speedily fell off. After a time I excised five of the tumors and touched the base with solid nitrate of silver.

A section of one of the tumors exhibited a distinctly lobulated structure, the loculi being packed with epithelial and adipose cells.

In relation to the disputed question of the contagiousness of this disease, it is proper to mention that the girl's mother noticed that when the child squeezed out any of the tumors, wherever the contents adhered to the skin there a new tumor appeared.

Dr. TILBURY FOX has no doubt of its contagious nature, although Dr. D. Duckworth (as also Dr. Fagge) has failed in his attempts at inoculation (St. Barth. Hosp. Rep. Vol. vii.). See two interesting cases in point by Dr. EAMES and Dr. FARRIER, Brit. Med. Journ., Dec. 21, 1872.

Some years ago I met with an extremely well-pronounced example of *molluscum sebaceum* remarkable for the number and extent of the glandular tumors. (Proceed. Path. Soc., Dub., New Ser., Vol. v.)

## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY

REPORTED BY DR. BULKLEY.

*Fifty-sixth Regular Meeting, April 7, 1874.*

DR. DRAPER presented a patient with an unusual form of disease of the skin, which he was inclined to call *Scrofuloderma*. (The history and description of this case, with the discussion, will be reserved for a later issue, as the patient is still under treatment by electrolysis. — ED.)

Dr. STURGIS demonstrated deep lesions of the eye following syphilis in two cases. (See ARCHIVES OF DERMATOLOGY, Oct., 1874, p. 57.)

Dr. MCBRIDE read the paper of the evening, entitled "Chronic Inflammations of the Testicle," which, owing to the lateness of the hour was not discussed

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*Fifty-seventh Regular Meeting and Sixth Annual Meeting,  
May 12, 1874.*

The annual reports of the Secretary, Librarian, and Treasurer were read and approved

The secretary reported the society as numbering 6 honorary, 24 corresponding, and 18 active members, including four additions during the past year; the largest attendance during the year had been 15 members. Ten meetings had been held during the year, at each of which some special order of business, papers, etc., had been prepared by a member or members. The library had received certain additions by donations from members. The treasurer's report showed a favorable state of the finances.

Dr. E. BAZIN, of Paris, in recognition of his life-long service to Dermatology, and his retirement from the Hôpital St. Louis at the age of seventy years, was made honorary member of the society, having been previously corresponding member.

Dr. OSCAR SIMON, of Berlin, was elected corresponding member.

The following officers were then elected for the ensuing year: President, R. W. Taylor; Secretary and Librarian, L. D. Bulkley; Treasurer, F. L. Satterlee; Executive Committee, F. P. Foster, E. L. Keyes, F. R. Sturgis, and President and Secretary, *ex-officio*. Drs. Sturgis and Bulkley were elected delegates to the American Medical Association, with Drs. Foster and Satterlee as alternates.

Dr. BEARD, by invitation, presented a patient with *herpes zoster frontalis*, in whom very excellent results had been obtained by electrical treatment.

Henry A., a blacksmith, aged about 40, usually enjoying perfect health, suffered from pain over the right eyebrow, temple, and forehead, one week previous to the appearance of the eruption. When seen, on the third day of eruption, the pain was terrible, but was greatly relieved at once on the application of the constant current locally, no heed being paid to the location of the poles or the direction of the current. The pain remained nearly absent for twenty-four hours after each sitting. When shown to the society the eruption was well in the decline, there being no very recent trouble, and much of the space which had been affected was covered by dried crusts. The eruption involved most of the forehead and extended back on the head to the vertex, and appeared slightly on the nose toward the root. There was some conjunctivitis and chemosis when first seen, but the eye was not seriously affected.

Dr. TAYLOR alluded to the pathological anatomy of herpes, which had been given recently by Wyss, indicating its nerve relations.

Dr. BEARD spoke of the rarity of ophthalmic herpes, but one case occurring in 102 cases of herpes in the General Hospital of Vienna, but, as the eye is generally affected patients go rather to eye hospitals.

Dr. KEYES had seen two cases of the disease in which the eyelids were affected, but the eyes escaped. Electricity was *not* used; there was loss of hair on the site of the vesicles.

Dr. BRONSON exhibited a patient with *lichen scrofulosorum*.

The patient was a young girl, 17 years of age, whose father and several of the family had died of consumption. The whole surface was covered with a papular eruption of a reddish brown color with a very small amount of scaling. The papules were arranged somewhat in groups, and were well marked on the back and chest and abdomen. The eruption had been noticed  $2\frac{1}{2}$  months, it gave little or no annoyance, no itching or irritation. There was quite abundant acne simplex and punctata present, indeed, in some parts of the eruption on the back, the acne element predominated.

Dr. Fox agreed as to the diagnosis, remarking that the disease could not be syphilitic, the only other eruption which could be mistaken for it.

Dr. BULKLEY said that the eruption corresponded to that named lichen scrofulosorum in Vienna, as he had observed it there. After further debate on the subject of the mode of action of electrical currents, the society adjourned.

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## NEW YORK SOCIETY OF NEUROLOGY AND ELECTROLOGY.

*Regular Meeting, November 16, 1874.*

DR. BULKLEY read a paper on "*The relations of the nervous system to diseases of the skin*,"\* in which the subject was treated of under the following heads:

1. Microscopic anatomy of the skin, with special reference to its nerve elements.
2. Physiological considerations: A, the mode of production of skin lesions through nerve influence, whether (a) by the vaso-motor nerves, that is through the contraction and dilatation of blood-vessels, or (b) by the action of special trophic nerves; B, the results of experimental section and irritation of nerves; C, arguments drawn from regional distribution of nerves and the corresponding cutaneous phenomena; D, reflex nerve influence.

3. Pathological observations: A, eruptions directly consequent upon *peripheral wounds of nerves*; B, eruptions attending *lesions of conducting nerves*; C, eruptions accompanying *brain and spinal*

\* Archives of Electrology and Neurology, November, 1874.

disease; D, idiopathic nerve lesions found *post-mortem* in nerves supplying diseased skin.

4. Resumé and deductions.

5. Therapeutic considerations.

The conclusion was reached that anatomical, physiological, pathological and therapeutical arguments all tended to confirm the fact that a large number of cutaneous lesions could be produced by nerve action, rendering it highly probable that many of the more ordinary forms are largely connected with, if not entirely dependent on, nerve or ganglion changes, which latter, while they may have escaped observation hitherto, may yet be demonstrated with much certainty in the future.

Dr W. H. DRAPER remarked, in discussion, that his clinical experience would bear out to a very great degree what Dr. Bulkley had said with reference to the nervous origin of many affections of the skin; but there were many points that he did not consider necessarily proven. Thus, he did not regard that the cutaneous changes, normal and pathological, attending pregnancy were the result of reflex action. If the *herpes gestationis* of Dr. Bulkley were reflex, why does it not occur oftener? He was rather disposed to consider these alterations as the result of blood changes. He had seen the case described by Dr. Bulkley as *herpes gestationis*, and had seen one other case of vesicular disease, apparently dependent on pregnancy, and this was on the hand and assumed rather the character of eczema.

As to lesions of nerve trunks causing cutaneous disease, he recalled the case of a gentleman who, in youth, received an incised wound of the hand, which was followed by atrophy of the middle, ring and little finger, and he has ever since suffered from eczema of the palm of that hand; but, strange to say, he has also eczema of the other hand as well; he is, however, a very gouty subject. He would rather then, in this instance, consider the eczema as the result of the gout, aggravated by the nerve injury; otherwise, we would expect to find the disease confined to the wounded hand.

His experience would also sustain what had been said as to the effect of trigeminal neuralgia on nutrition of the hair, the hair turning white before falling, along the track of affected nerves. He had never been able to find a parasite in alopecia areata, and now regarded the disease as neurotic.

Dr. E. L. KEYES said that he had met with eczema of the hand

after nerve injury, and believed much in certain nerve relations of some eruptions. Thus, in a peculiar case of pruritus of the scrotum, the patient was a very nervous, high-strung gentleman, who worked very hard, had had a hard struggle in life and had often become very much wrought up, in religion as well as in his daily occupation. He was subject to neuroses, and at one time he became insane, and it was after the disappearance of insanity that the pruritus of the genitals occurred. Various measures of relief were ineffectually tried until a trip to the hot sulphur springs removed the difficulty.

He thought the neural connection was very marked in this instance; as to therapeutics, there had not been much of intelligent treatment of this class of neurotic diseases before the introduction of electricity.

Dr. G. M. BEARD remarked further, in regard to the literary lady mentioned by Dr. Bulkley, in whom there was the intense itching of the right arm, returning with each mental overstrain and resisting treatment while it was kept up. Relief had been obtained by electricity, as Dr. B. had stated, and the peculiar fact in reference to this was, that the current had not been applied at all locally, but had been always given by the method known as central galvanization. Three weeks ago he had commenced the treatment, applying a moderately strong current to the brain, spinal cord and sympathetic. With this there began to be itching elsewhere; the left arm gave annoyance, and there was a certain amount of general pruritus. This has all, however, disappeared with the continuance of the treatment. There was no other means employed until quite lately, when she began to take iodoform and iron internally. Among the neuroses she has suffered from since the galvanization, is an odontalgia.

In further reference to neurotic relations of skin diseases, and their appropriate treatment, Dr. Beard stated that there were now six cases of chronic eczema, with intense pruritus, which had been treated and *cured* (?) by central galvanization, little or no application being made to the diseased surface. Two of these appeared in the ARCHIVES OF DERMATOLOGY for October, 1874, page 55.

Dr. BULKLEY, in conclusion, said, that he could not understand how the chromatogenous and other cutaneous alterations, normal and abnormal, in pregnancy, were any better explained by a supposed alteration in the blood, as one of the speakers had intimated, than through the influence of the nervous system. The pruritus

of pregnancy disappears with the emptying of the uterus, almost instantaneously, as does also the herpes gestationis. Now, were these dependent on blood changes it were hardly possible to suppose that that fluid could as suddenly regain its normal condition as the facts would require. If cutaneous alterations were dependent on blood dyscrasias why do they not occur oftener? the burden of proof lies quite as strongly on those maintaining the humoralistic doctrines as on the neuro-pathologist, especially as it had shown in the paper\* that these lesions may be the direct result of nerve injury, whereas nothing has been *proven* in regard to the influence of blood states directly on cutaneous tissue.

Further, the presence of uterine fibroids will cause the development and continuance of acne rosacea, which disappears shortly after their removal; do we imagine that the existence of so harmless an affair as a small fibrous tumor in the uterus or its walls involves blood changes causing the acne? and that the blood returns to its normal state on the surgical removal of the offending mass? Far more reasonable is the supposition of nerve irritation, reflex in character, which, as has been shown repeatedly, is capable of inducing many changes.

Finally, the great variety and number of skin alterations which had been cited in the paper as directly connected with nerve injury and alteration, together with the relief afforded many of them by section of the nerve, would seem to warrant the belief that future pathology will demonstrate that very many of the ordinary forms of cutaneous lesion have their origin in nerve irritation, central or peripheral, idiopathic or caused by contact with foreign and irritating bodies, local or internal.

\* Archives of Electrology and Neurology, Nov., 1874.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### CLASSIFICATION, DIAGNOSIS, ETIOLOGY, ETC.\*

E. B. BRONSON, M. D.

1. **Southworth, J. W.** — A new classification of skin diseases. Buff. Med. & Surg. Jour., Feb. 1874.

2. **Bulkley, L. D.** — The necessity of a correct diagnosis in diseases of the skin, illustrative Cases. Amer. Pract., Aug., 1874.

3. **Rathery.** — Diagnosis between arsenical and syphilitic eruptions. L'Union Méd., 25, 1874.

4. **Bailey.** — Dartrous affections. Nash. Jour. Med., Nov. 1874.

5. **Ephstein.** — Have the Jews any immunity from certain diseases. Med. & Surg. Reporter, 918, 1874.

6. **Fox, T.** — Skin eruption in a child caused by bromide of potassium taken by the mother. Lancet, Nov. 7, 1874.

7. **Gaskoin, Geo.** — Relations of cancer to skin disease. Med. Times & Gaz., May, 1874.

8. **Merrick, J. M.** — Compositions of cosmetics, hair-dyes, etc. New Remedies, Oct., 1874, p. 362.

9. **Profeta, G.** — Skin diseases symptomatic of rheumatism. An. de derm. et. de syph., Vol. V, No. 6, p. 471.

10. **Purdon, H. S.** — Eruption peculiar to flax spinners. Dubl. Jour. Med. Sci., June, 1874; also Lancet, Nov. 21, 1874.

11. **Uffelmann.** — A disease of the skin peculiar to children. Arch. f. klin. Med. (Med. Times & Gaz., Jan. 17, 1874.)

12. **Buckley, L. D.** — The practical management of diseases of the skin. Virg. Med. Monthly, Nov., 1874.

\*Press of matter prevents us from giving more than the titles. ED.

13. **Kirchner.**—Cod-liver oil in skin diseases. *Berl. Wochenschr.*, 1, 2 (Practitioner, July, 1874, p. 57).
14. **Peyraud.**—Bromide of potassium in the destruction of tumors. (*N. Y. Med. Jour.*, Nov., 1874, p. 541).
15. **Ringer, S.**—Sulphides of potassium, sodium and calcium (in the treatment of suppurative affections). *Lancet*, Feb. 21, p. 264, and Feb. 28, 1874, p. 317.
16. **Vanderbeugle.**—Incompatibility of Fowler's Solution and Magendie's Solution. *New Remedies*, Oct., 1874, p. 343.
17. **Wilson, E.**—Gurgon oil in skin diseases. *Lancet*, May 16, 1874.

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## DISEASES OF THE GLANDS.

LOUIS A. DUHRING, M. D.

1. **Aubert, P.**—Action of the sweat upon metallic salts, and considerations concerning the sweat and the functions of the glands. *La Trib. Méd.*, No. 299, 1874, from *Lyon Méd.*
2. **Foot, A. W.**—Chromidrosis. *Irish Hosp. Gaz.*, December 1, 1873.
3. **Grimshaw.**—Bromo-hyperhydrosis of the feet. *Irish Hosp. Gaz.*, Feb. 16, 1874.
4. **Hardy.**—Hyperhydrosis localized upon the soles of the feet and upon the palms of the hands. *Archiv. Méd. Belges*, Sept., 1874.
5. **Hofmann.**—Chromidrosis. *Wiener Med. Woch.*, No. 13, 1873.
6. **Ogston, A.**—Dyshydrosis, case of. *Brit. Med. Jour.*, April 25, 1874, p. 546.
7. **Ollivier.**—Partial Hyperhydrosis of the face. *Gaz. Méd. de Paris*, No. 24, 1873.

Dr. Foot (2) details a case of this curious affection—chromidrosis—occurring in a nervous, excitable girl of seventeen. After a severe headache a blue spot showed itself upon the forehead having all the characteristics of sweat. Occasionally it appeared over the whole face, and was apt to be produced by exertion. Patient was subject to headache; bad appetite; catamenia somewhat suppressed. On one occasion the blue sweat appeared on the back of the hand. Various kinds of internal treatment were

adopted, a general tonic course being of greatest benefit. The only local treatment considered of any value was a lotion of hypo-sulphite of soda, one drachm to the ounce of water. The affection disappeared entirely at the end of a year's time.

An example of *bromo-hyperhydrosis*, under the care of Dr. GRIMSHAW (3), is reported as having been produced by the wearing of vulcanized India-rubber soled slippers. After wearing the slippers a few days, the feet became cold and white and began perspiring freely; redness and swelling, together with burning and a sensation of extreme pain, followed. Patient feverish with general malaise. Patient recovered in the hospital in two weeks, under quinine mixture and  $\frac{1}{100}$  gr. atropia every three hours.(!) The India rubber was examined, but found to contain nothing unusual.

HARDY (4) gives the details of one case of *hyperhydrosis of the feet*, and another case of the same disease attacking both the feet and the hands. The first case was completely cured in two weeks, while the second was greatly benefited in three weeks, and doubtless would have been cured, had the patient not left the hospital. The treatment employed in both cases was that introduced to the profession by Hebra, employing, however, simple diachylon plaster in the place of unguentum diachyli.

Dr. HOFMANN (5) relates a case of *chromidrosis*, occurring about the scrotum and thighs, in an old man seventy-two years of age. The sweat was bluish-black in color and was found to contain indigo.

An interesting case of *partial hyperhydrosis of the face* is narrated by Dr. OLLIVIER (7). The man suffered from a local sweating of the portion of the face supplied by the second division of the fifth nerve. The patient's maternal grandfather, a daughter of the latter and one of her children were said to have been subject to the same peculiar disorder.

8. **Hardy.**—*Acne sebacée et pityriasis du cuir chevelu.* L'Union Méd. du Canada, November, 1874.

9. **Neumann, Isidor.**—Diseases occurring upon the hand, due to the internal use of the bromide of potassium. *Wiener Med. Woch.*, No. 49, 1873.

10. **Neumann, Isidor.**—Diseases of the skin produced by the internal use of bromide of potassium. *Aerztlicher bericht über die im städt. Communal Spital Zwischenbrücken im Jahre, 1872, 1873, behandelten Blatternk. etc., mit Anhang, Wein,* 1874.

11. **Neumann, Isidor.**—Recent observations upon bromide of potassium eruptions. *Wiener Med. Presse*, No. 22, 1874.

12. **Sparks, Edward.**—On a disease of the skin produced by the acarus folliculorum; illustrated by cases observed in the dog. *Med. Chir. Trans.*, vol. 57, 1874.

13. **Duhring L. A.**—Seborrhœa capitis. *Phil. Med. Times*, May 2, 1874.

Dr. NEUMANN (9) cites the case of a child, five months old, who showed an eruption after taking twelve scruples of the bromide. An examination of the skin revealed the hair follicles and sebaceous glands, together with the upper part of the corium, to be the seat of the disease. The glands were very much enlarged and contained pus, epithelial cells and masses of smegma. The papillæ were observed to be increased in size and the whole of the corium highly developed.

The same writer (10) gives, in a short paper, a resumé of the subject, together with three cases (one of which is the same case as that reported in the above article). The pathological anatomy is entered into and the abnormal condition illustrated by wood-cuts. The author holds the view that the bromide of potassium is poured into the sebaceous glands of the skin and there causes inflammation together with an increase of cell growth.

Dr. SPARKS (12) found in three dogs, affected with loss of hair, scaliness and pustulation, resembling acne, who died while under observation, great numbers of acari, the same as in man, occupying the glands and follicles. Reasoning simply from analogy, Dr. S. thinks this may prove one of the causes of acne in man in certain cases. The writer, however, brings forth no proof of this theory in his paper.

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## INFLAMMATIONS; ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M. D.

1. **Baker, W. M.**—Erythema serpens. *St. Bartholomew's Hospital Reports*, Vol. IX.

2. **Meyer.**—Artificial Erythema. (*Erythema artificiel.*) *Archiv. für Psychiatrie und Nervenkrank.* Band IV, Heft. 3.

3. Erythema papulatum et nodosum. *Gaz. des Hôp.* 68, 71.

Mr. BAKER (1) describes a series of cases of an affection to which he gives the title *Erythema serpens*. The patient complains of pain in the hand or fingers, and on examination there is seen an inflammatory blush, pink rather than red in color, in the form of blotches gradually fading into the natural skin. (A colored plate represents the appearances.) It affects the finger joints and knuckles principally, and the patient bends them cautiously. There is, however, but little swelling of the parts. The pain is considerable, of a tingling, smarting, burning, or shooting character, and is mostly confined to the fingers and hands, occasionally extending up the arm, but rarely accompanied by any streaks or line of redness on the latter part. The constitutional disturbance is very slight, but the patient often experiences a dread of "something worse happening." The history of the cases is generally that, a few days or a week before the appearance of the affection there was some slight injury or scratch inflicted upon the hand or finger, the seat of which may be discovered upon close examination. There is never any suppuration or other lesion of the point, however. It is not even tender, but it will be seen to be the centre of the redness at the start, which, spreading equally in all directions, soon breaks up into paler pink blotches and scattered spots. As it progresses the parts first reddened become pale, as the periphery extends, as in ordinary erythematous. The cause seems to be the introduction of some harmful matter at the site of the injury, which is generally found to be some decomposing animal matter, the affection occurring especially among butchers. It always ends in resolution, and its duration is from two to six weeks. It seems to be closely allied to erysipelas ambulans.

4. **Scheiber.**—Pellagra. Pest. Med., 3, and Chir. Press, x, 1, 2.
5. **Siredey.**—Pseudo-Pellagra. L'Union Mèd. (Vierteljahrssch. für Derm. und Syph. 1 Jahrg., 1874, p. 112.)
6. **Tamburini.**—Transfusion of blood in Pellagra. Lo Sperimentale, Aug., 1874. (N. Y. Med. Record, Nov. 16, 1874. p. 595.)
7. **Hardy.**—Urticaria. L'Union Med. du Canada, Nov. 1874, p. 513.
8. **Rendu, H.**—Alterations of sensibility in inflammations of the skin (Recherches sur les alterations de la sensibilité dans les affect. de la peau) Annal. de Derm. et de Syph., v. No. 6, 1874.

In the investigations here (8) only partially published, RENDU has tested, in many of the affections of the skin, the disturbances

in its sensibility to three distinct impressions; to touch, to pain, and to temperature. In simple inflammation, that produced by a blister, he found that the tactile sensibility of the surface before the formation of the bulla was considerably increased. The sensation of pain was exaggerated also, but the affected skin showed a blunted perception of heat or cold. The same tests were also applied in erysipelas, in several varieties of erythema, and in herpes. In the first named, as in the inflammations artificially produced, there were hyperesthesia and hyperalgesia, but a less acute perception of temperature. In the latter affections there was a slight exaltation of the tactile sense only in some cases, whereas in others there was no modification in the sensibility; showing a marked difference, in this respect, between simple congestion and the early stage of dermatitis.

9. **Humphreys, C. H.** — Poisoning by *Rhus Toxicodendron* Sulphate of zinc in. Am. Jour. Med. Sci., July, 1874, p. 160.

10. **Bergmann.** — On the treatment of frostbite. (Zur Behandlung der Erfrierung.) Vierteljahr. für Dermat. und Syph., 1 Jahrg., 1 Heft, from Med. Rundschau.

BERGMANN (10) calls attention to the fact that in freezing the contraction of the vessels is followed, when the cold abates, by an enlargement, beginning at the capillaries of the veins and arteries, causing a retardation of the circulation and, consequently, blueness, œdema, and often even gangrene of the part. He recommends the use of vertical suspension of the frozen part, and narrates a case in illustration of its superiority to the passive method in the stage of reaction.

A young man, who had been exposed to the cold several hours and had become stiff, was brought in senseless and placed in a cool bath which was gradually warmed. The pulse soon rose from 50 to 130, and consciousness returned. In ten hours the hands and feet, especially the latter, were of a dark blue color, and considerably swollen. The lower extremities were then suspended several feet above the level of the bed, while the hands were merely covered with cool compresses. At the end of 24 hours portions of normally colored skin began to appear upon the feet. In a week the blueness had entirely disappeared, the bullæ had dried into crusts under which a new epidermis was forming, and at two points only had superficial gangrene developed, leaving, when cast off, clean wounds, which quickly healed.

On the hands, which were not suspended, the course was much more unfavorable. On the third day, when both hands were strongly swollen, the dorsal surfaces of the fingers and hands were covered with large blisters, and several broad red streaks were seen running up to the elbow, the upper extremities also were placed in suspension. The good results were visible in 24 hours; the red streaks had disappeared, and the blueness and swelling were gone. The bullæ gradually dried up, and gangrene was developed beneath but few of them, which upon the right remained superficial and soon gave place to healthy wounds. Upon the left, however, it extended deeper, so that several of the phalanges dried up into black, hard masses.

Bergmann attributes the less favorable result upon the hands to the fact that they were not suspended until three days after the feet.

**11. Aufrecht.** — Erysipelas treated by sub-cutaneous injections of carbolic acid. *Med. Centralbl.* x, ii, 9, *Brit. Med. Jour.*, No. 695.

**12. Bellevue Hospital.** — Erysipelas treated by the tar method. *N. Y. Med. Jour.*, Oct., 1874, p. 414.

**13. Cadiat, M.** — Phlegmonous erysipelas. (*Note sur l'érysipèle phlegmoneux.*) *Journal de l'Anat. et de la Phys.* 1874, p. 410.

**14. Chisolm, J. J.** — Erysipelas treated by iron. *N. Y. Med. Jour.*, Oct., 1874, p. 358.

**15.** Erysipelas in the puerperal condition. *Brit. Med. Jour.*, May 16, 1874. (*Am. Jour. Obstet.*, Aug., 1874, p. 341.)

**16. Fredet.** — General phlegmonous erysipelas in a child 12 days old; recovery in 50 days. *Gaz. des Hôp.*, July 28, 1874; (*Am. Jour. Obstet.*, Nov., 1874, p. 527.)

**17. Greene, W. F.** — Two fatal cases of erysipelas. *Med. Press and Circular*, May 27, 1874, p. 444.

**18. Kaczorowski.** — Turpentine in erysipelas. *Berliner Klin. Wochenschr.* (*Archiv. für Derm. und Syph.* Heft 4, p. 579.)

**19. Le Monnier, Y. R.** — Erysipelas and its treatment by sulphate of quinine. *N. Y. Med. Jour.*, Nov., 1874, p. 530.

**20. Lordereau.** — Sur les différents modes de production de la suppuration à la suite de l'érysipèle et sur les variétés qu'elle présente. *Archiv. Générales*, March, 1874.

**21. Lutz.** — Erysipelas migrans in a child four weeks old, favorable termination. *Archives für Klin. Med.* (*Am. Journ. Obstet.*, Nov., 1874, p. 527.)

22. **Mapother, E. D.**—The nature of Erysipelas. Med. Press and Circular, Jan. 21, 1874, p. 49.

23. **Minor, T. C.**—Erysipelas and child-bed fever, pp. 131. Cincinnati, R. Clarke & Co. N. Y. Med. Jour., Nov., 1874, p. 531.

24. **Perroud.**—De l'érysipèle rheumatismal. Annales de Dermat. et de Syph. Tome 5, p. 161.

25. **Reid, J.**—On erysipelas during the puerperal condition. Brit. Med. Jour., May 16, 1874, p. 646.

26. **Sevestre.**—Cardiac manifestations of facial erysipelas. Gaz. des Hôp., 51.

27. **Stewart, W.**—Erysipelas during the puerperal condition. Brit. Med. Jour., Sept. 5, 1874. Am. Jour. Obstet., Nov., p. 523.

28. **Tibbits, R. W.**—On erysipelas in hospital and in general practice. Lancet, June 13, 1874.

29. **Tutschek.**—Complete obstruction of the abdominal aorta following erysipelas faciei. Vierteljahresschrift für Derm. und Syph. 1 Jahrg. p. 107, from Aerztl. Intell. Bl.

30. **Vincent, F.**—General erysipelas in new born infants. Gaz. des Hôp., Aug. 18, 1874. Am. Jour. Obstet., Nov., p. 528.

Dr. AUFRECHT (11) acting on the recent observations which seem to connect the production of erysipelas with the entrance of minute organisms into the cutaneous tissues (see page 67 of the Archives of Dermatology), and the reputed power of carbolic acid to destroy such germs, was led to try its effect in arresting the spread of erysipelas. He first injected into his own subcutaneous tissues six decigrammes (about ten minims) of a one per cent solution, without any local or general disturbance. He then applied the treatment in a case of erysipelas of the forearm and hand, and in one of the leg. In the first he injected carbolic acid night and morning for three consecutive days, five injections in all; in the second four injections in two days. They were made into the healthy subcutaneous tissue in the neighborhood of the erysipelatous portion lying nearest the body. The erysipelas did not spread in the direction of the part where the injection was made; but some isolated patches above the points first injected necessitated the more frequent injection of the remedy. Not only was the erysipelas arrested; but the fever and the frequency of the pulse were reduced, and the general condition of the patients was improved. The erysipelatous swelling and red-

ness diminished perceptibly, remaining only two days after the injections.

CADIAT (13) calls attention to the error which is often committed of confounding *phlegmonous erysipelas* and *true phlegmon*, and gives the main points of difference between the two afflictions. The characteristic lesion, according to him, of erysipelas is congestion of the papillary layer, producing turgescence and disturbance of the circulation, an inflammatory process of the superficial portion of the cutis, as in the eruptive fevers, erythema, and the like. Under some circumstances the subjacent parts may be also affected, but always secondarily. In phlegmon, on the other hand, all this is reversed; the corium is not inflamed except secondarily, the papillary layer is not turgescent, and the redness of the skin is only a reflection, so to speak, of the congestion of the deeper layers. Such are the differences at the start of the two afflictions, and they are not narrowed by their progress. After some days, sometimes at the beginning, sometimes at the moment when suppuration is established, there is often a considerable œdema developed in the parts affected by phlegmonous erysipelas, which is probably due to disturbances in the lymphatic circulation. The affected tissues are "flabby," giving over their whole extent a deceitful impression of fluctuation. In phlegmon on the contrary, the œdema is hard, and when the subcutaneous layer becomes soft, the sensation of fluctuation imparted is always indicative of the presence of pus. In phlegmonous erysipelas suppuration is established a little later than in phlegmon, about the tenth day, but in an entirely different manner. The elements of pus form in the lymphatic plexus and in the lower layers of the corium, as shown by Vulpian, Volkmann, Steudner and others. The suppuration remains for a longer or shorter time confined to these parts which it attacks successively, forming scattered, separated abscesses in the beginning, which may gradually enlarge and form continuous fields of suppuration. Thus it is that the suppuration, enclosed at first, is less inclined to invade the subcutaneous layer, which never mortifies, but is destroyed progressively. The skin, too, when the process has been very intense, only ulcerates slowly and never becomes grangrenous. In phlegmon it is not the corium which is first attacked, but the underlying layers. The whole mass of these tissues is affected at a blow and the pus is formed everywhere at once, while the skin above, attacked only secondarily, often remains intact, even when large suppurations

are formed below it. The mortification of the cellular tissue often precedes the formation of pus.

We see, therefore, that in seat and course, in consecutive lesions and the manner in which the abscesses are developed, there are notable differences between these two affections, as well as in the methods of their treatment. In erysipelas, whatever its form, it is necessary to incise only at the last moment. Incisions do not arrest the progress of the inflammation, and when the pus is formed, one is liable, on puncturing too soon, to see the skin open of itself by the side of the incisions made by the knife. In phlegmon, on the other hand, it is necessary to penetrate as soon as possible to the lowest layer to relieve the tissues which are the seat of the inflammation and purulent effusion.

[PERROUD (24) quotes various authors who have noticed a connection between *erysipelas* and the *rheumatic diathesis*, and gives details of six cases. The erysipelas may occur during the course of acute or chronic rheumatism, and sometimes precedes effusion into the joints. The redness and swelling are moderate, with a considerable ambulant tendency. Relapses are frequent. Glandular engorgements are less common than in other forms of erysipelas. The affection often alternates with arthritic manifestations, and disappears without special treatment. — ED.]

31. **Kochman.** — Furuncular inflammation. *Archiv. für Derm. und Syph.*, Heft 4, p. 325.

32. Furuncle and its relation to herpetism. *Bulletino delle Sci. Med. Maggio*, 1874, p. 383.

33. **Carpenter.** — Malignant pustule; report of five cases, *London Medical Record*, July 29, 1874.

34. **Cezard, M.** — Charbon (*Traitément des maladies charbonneuses*). *Gaz. Méd. de Paris*; *Arch. Méd. Belg.*, Sept., 1874, p. 197.

35. **Bourdon.** — Treatment of herpes zoster. *La France Méd.*, (N. Y. Med. Jour., August, 1874, p. 217).

36. **Bulkley, L. D.** — Herpes gestationis; a rare affection of the skin, peculiar to pregnancy. *Am. Journ. of Obst.*, Feb. 1874.

37. **Carry.** — Herpes ophthalmicus; frequent recurrence of. *Lyon Médical*, No. 14. (Lond. Med. Record, Sept. 23, 1874).

38. **Duckworth, Dyce.** — Herpes caused by arsenic (?). *St. Bartholomew's Hospital Reports*, vol. 9.

39. **Hamisch.**—Herpes zoster. Deutsch. Arch. für klin. Med., Heft 13, p. 183.

40. **Hybord, A.**—Zona ophthalmique et des lésions oculaires qui s'y rattachent. Thèse de Paris. (Annales de Derm. et de Syph., Tome 5, p. 63.)

41. **Jeffries.**—Ophthalmic herpes (Bost. Soc. Med. Sci. Trans.). N. Y. Med. Jour., November, 1874, p. 514.

42. **McCrea, John.**—Complicated herpes zoster. Dublin Journal of Medical Science, October, 1874.

43. **Lagout.**—Observation d'herpes labialis, fièvre d'élimination à type intermittent tierce. Union Méd., No. 81.

44. **Ollivier.**—Zona and intercostal neuralgia, connected with cancer of the lung (Soc. de Biologie, May 2, Rev. Scientifique). Absts. in Chicago Jour. of Ment. and Nerv. Dis., Oct. 1874, p. 554.

BULKLEY (36) describes as *herpes gestationis* a rare affection of the skin which he believes peculiar to pregnancy, recording one case and quoting eight others, almost precisely similar. The features are thus summed up :

1. There is an affection of the skin directly dependent upon the gravid state of the uterus, which may make its appearance at any period of gestation up to the seventh month, and generally continues until the organ is emptied of its contents, and has, in a measure, resumed its former state; this eruption is very apt, moreover, to recur at each successive conception.
2. The cutaneous manifestations are chiefly an intense irritation, consisting of burning, itching, or stinging, and sometimes pains, with the development of erythema, papules, vesicles, and bullæ up to the size of a hen's egg, the majority of the blebs, however, seldom surpassing in size a large bulla of herpes. These vesicles are commonly in groups, but do not follow any definite nerve-tracks, appearing first, generally, on the extremities; and afterwards involving the larger part of the body. Exhaustion may ensue from the cutaneous irritation, but the disease is non-febrile.
3. The eruptive disease does not terminate at once after delivery, but slowly retrogrades by the development of fewer and fewer vesicles at increased intervals, until the disposition thereto ceases entirely. An outburst of greater or less severity is most likely to happen on the third day; it is rare for any manifestations of the disease to remain a month after parturition.
4. This affection is sometimes accompanied or followed by other

neurotic manifestations, as erythema, urticaria and neuralgia, which may continue in the interval of conception, while in many instances the patient experiences perfect health in the *interim*.

5. This eruption has occasionally been the first indication that impregnation has taken place.

6. The majority of cases have been uninfluenced by treatment, relief occurring only on the emptying of the uterus.

7. The children are not, as a rule, affected by the eruption in the mother, although in one case it was accompanied in two instances by a still-birth; here, however, the first eruption was followed by the delivery of a living child, whereas the second conception gave a still-born child without any maternal eruption.

This affection should not be confounded with the one occurring in pregnancy observed and described by Hebra, nor with the acute general febrile herpes of Coutagne, or the cases given by Neumann as herpes, nor yet with eczema, the clinical features in the cases quite precluding this.

CARRY's patient (37), with *ophthalmic herpes*, was a girl sixteen years old. Admitted to the hospital for chronic rheumatism, she was seized a week afterwards, at night, with intense intra-orbital pain on the left side. In the morning the eyelids were found red and swollen, and studded with a vesicular eruption, which extended to the cheek, and soon coalesced to form bullæ. The pain was much increased by pressure upon the supra-orbital and infra-orbital nerves. In three days the efflorescence disappeared. A week afterwards there was a fresh attack of pain and a similar eruption on the right side. Subsequently, there was a speedy recurrence on the left side with pain, also in the shoulder and axilla, and the appearance of vesicles on the root of the nose. After this the patient returned to the hospital several times with similar attacks, and, up to the time of reporting, the disease had recurred twelve times, twice upon the right and eleven times upon the left side.

This case approaches herpes perstans in frequency of recurrence and duration.

DUCKWORTH (38) reports a case of *sacro-coccygeal herpes* in a girl nine years old, who had been taking Fowler's solution for ten days. Pain was felt at the sacrum, and three days subsequently two patches of herpes were found, one on either gluteal region. There was no eruption on the mesial line, but the two patches subsequently coalesced. The affection appeared to be situated

over the course of the last sacral nerves. Dr. Duckworth reports the case mainly for the purpose of saying that it is the first in which he has seen a herpetic eruption in a patient while under the influence of arsenic. Mr. Hutchinson and other English writers have called attention to its not infrequent occurrence.

**45. Homolle fils.**—Epidemic of acute pemphigus among newborn children. *Gazette Hebdom.* 13 November, 1874.

**46. Moldenhauer.**—Contribution to the study of acute pemphigus. *Archiv. für Gyn.* (Am. *Jour. Obstet.*, Nov., 1874, p. 528.)

HOMOLLE (45) reports the particulars of an epidemic of *acute pemphigus* in la Charité which lasted from July 1st to September 14th. There were 79 births in this period, and but few of the children escaped the affection. On the fifth or sixth day after birth bullæ appeared in more or less considerable numbers, and sometimes in successive crops. They were of the size of a pea, hemi-spherical or semi-ovoid in shape, and contained a yellowish, feebly alkaline liquid. They were surrounded by a narrow red areola. After their rupture there was left a denuded and eroded surface, which was soon covered by a thin, brown crust. The eruption showed itself on nearly all parts of the body, particularly upon the neck and trunk, where it attained its greatest size. The palms and soles were always spared by the eruption. The general condition of the little patients seemed not in the least affected by the eruption, although in five or six of the cases there was also a catarrhal ophthalmia. Only one infant died—twenty-four hours after the beginning of the pemphigus—which was general and characterized by the appearance of large phlyctænae. The result of the autopsy in this case was negative. The mode of propagation was not determined. Inoculations proved negative, and vaccination from infants thus affected developed only vaccine disease in others. Contagion by direct contact seemed evident in one case. The relation of this and similar epidemics to varicella formed the subject of a communication to the Société des Hôp., which is noticed in the same journal.

The report of a similar epidemic in the Lying-in Hospital at Leipzig, from the *Archiv Gynaekol.* may be found in the *London Med. Record*, June 3.

## INFLAMMATIONS; CHRONIC AND PRURIGINOUS.

F. D. WEISSE, M. D.

1. **Stephenson, Wm.**—On the eczematous eruptions and eczematous asthma of childhood. *Obstet. Jour. Gt. Brit. and Ire.*, Aug., 1874.
2. **Balfour, T. G.**—Discussion on Dr. Stephenson's paper. (*Trans. Med. Chir. Soc. of Edinb.*) *Edinb. Med. Jour.*, Aug., 1874.
3. **Cunynghame, B.**—Discussion. (*Trans. Med. Chir. Soc. Edinb.*) *Edinb. Med. Jour.*, Aug., 1874.
4. **Macdonald, K. W.**—Cases of eczema complicated with asthma, etc. *Edinb. Med. Jour.*, March, 1874.
5. **Beard, G. M.**—Chronic eczema treated by central galvanization. *Archives of Dermatology*, Oct., 1874, p. 55.
6. **Bulkley, L. Duncan.**—The management of eczema. *Transactions of Amer. Med. Association*, 1874, p. 121-138.
7. **Bulkley, L. Duncan.**—“*Liquor picis alkalinus*” in eczema. *Detroit Rev. Med. and Phar.*, Sept., 1874, p. 451.
8. **Murchinson, C.**—Eczema in functional derangement of the liver. *Lect. iii, Brit. Med. Jour.*, April 25, 1874.
9. **Thornley, J. G.**—Carbolic acid in the treatment of eczema. *Med. Press and Circular*, May 20, 1874.
10. **Weisse, F. D.**—Relations of eczema to xeroderma and ichthyosis. (*Trans. N. Y. Dermatol. Soc.*) *Archives of Dermatology*, Oct., 1874, p. 49.

The article of Dr. STEPHENSON (1) is a most interesting contribution to the literature of our text, giving evidence of experience, judgment and practical deductions.

Dr. S. makes a most important point when he says: “It is dependence upon development which distinguishes the eczema of childhood from that of the adult. Under its influence we see its character modified according to the age of the child, we find it obstinate under treatment at the earlier stage, and amenable, or undergoing a spontaneous cure as the period peculiar to it draws to a close.”

As regards the self-limitation of eczema infantilis, Dr. S. says: “The sixth year, I believe, may be taken as the natural limit of

the constitutional form of eczema. In cases that have continued to the sixth year a decided spontaneous tendency to a comparatively healthy condition of the skin may be observed. After this time should the skin still manifest an unhealthy action it is generally limited to the limbs. There is abundant evidence to show that the sixth year is a developmental period which influences other affections as well."

The importance of treatment during the course of E. Inf. has not been lost sight of by Dr. S., as may be seen by the following:

"While acknowledging the spontaneous tendency to improvement, as age advances, a counter fact has been impressed on my mind, and that is, that nothing tends more to aggravate the affection and prolong its existence than leaving the disease to itself without proper local treatment."

That portion of the article of Dr. S., relating to eczematous asthma of childhood, consists of references to the general observations of Barthez, Rilliet, Caillaut and West on the subject, and the contribution of two well-marked instances of the affection. In both cases the E. appeared at two or three months old, respectively; the face and scalp improved at the third year. In the first case the age is not stated at which the asthmatic symptoms developed; but in the second case the first broncho-asthmatic attack occurred at two years and five months. In neither case was there any indication of metastatic relation between the skin and the lungs.

The continuance during childhood till about the sixth year, and that then both affections spontaneously tended to recovery, as if impressed with the developmental changes of the sixth year period, were the prominent features of the two cases.

The cases of Dr. S. differ in an essential particular from those of the authors he cites, in that he notes no metastatic relation between the skin and the tracheo-bronchial affection.

After the reading of Dr. Stephenson's paper before the Med. Chir. Society, Dr. BALFOUR (2) contributed the following interesting history:

"In the case of a child who, from the age of fourteen days, has suffered from general eczema of the whole body, if the eczema begins to moderate or nearly disappear, dyspnoea follows, and the chest becomes filled with bronchial rales, also at times there is heaviness of the head, as if congestion was present, followed by vomiting, which symptoms pass off whenever the skin again be-

came affected. The child is nearly two years old, and the disease is still going on."

Dr. CUNYNGHAME, during the same discussion (3), said:

"He had seen a family, all the members of which, during the period between the first and second dentitions, suffered from eczema of the body generally, with symptoms of spasmodic asthma, all of which pass off when the second dentition is over, leaving the skin healthy looking."

In this case of Dr. MACDONALD's (4), we have still another contribution to the *asthmatic complication of eczema*. The case may be epitomized as follows:

From birth, skin irritable; at six weeks old, eczema of face developed; subsequently E. extended in spots over whole body, Hair grew in patches only, and had a dry, stunted and withered look. Attacks of dyspnoea frequent, with chronic bronchitis (does not state age when tracheo-bronchial symptoms appeared). Case came into the hands of Dr. M., May, 1872, when the boy was six and three-quarter years old; and after six months' treatment recovered, and up to December, 1873, skin had been well, but a wheezing respiration still remained at that date.

The interest of this case is enhanced by improvement taking place after having lasted to the sixth year. It gives additional weight to the statement of Dr. Stephenson, and, indeed, would seem another happy verification of "the sixth year period of self-limitation" advanced by him.

After reviewing the most recent views on the pathology of the disease, Dr. BULKLEY (6) enters upon the *management of eczema*. First considering the forms induced by artificial causes, he states that all that is needed for them is to remove the cause, and then allay the local symptoms produced. Subdividing all other cases into acute and chronic, Dr. B. notes the treatment for each variety respectively.

Of the acute form, he says, that it "is now widely recognized as running a definite course through certain stages, which can as seldom be aborted as can gout or rheumatism, and which can only be modified and relieved by soothing treatment."

While acute he recommends lotions which on evaporating leave a finely divided powder on the part, for example: Rx Zinci carbonat., 3 ij to 3 ss; zinci oxidi, 3 i to 3 ij; glycerine, 3 ij; liq. picis alk., 3 i; aq. rosae, 3 iv. M. When exudation has ceased, ointments are useful, as much because by being oily they ex-

clude air, as by virtue of any medicaments they may contain. Dr. B. has used simple mutton suet with great advantage.

Chronic E., which the writer regards as "the product of the acute form which has induced a morbid cell action in a portion of the skin," he treats by revulsive applications. Of Hebra's treatment Dr. B. says :

" My experience is that American skins will not stand his very harsh applications; nor will our patients submit to such painful treatment."

Dr. B. advances a very valuable preparation of tar and potassa for the local treatment of E. in its chronic stage, relieving itching and diminishing thickening of the skin, viz. :

Rx	Picis liquidæ,	3 ij.
	Potassæ causticæ	3 i.
	Aquæ distillatæ	3 v.

M. ft. solutio. To be used diluted.

(The stick potassa is to be dissolved in the water and gradually added to the tar with rubbing in a mortar.) This preparation he calls "Liquor picis alkalinus."

This Dr. B. applies diluted, undiluted, and at times even, he increases the amount of caustic potassa if the thickening of the skin demands it. This combination may be also advantageously added to ointments such as the citrine, white or red precipitate in the proportion of 3 ij to 3 iij of either of the unguents to 3 i of simple ointment, and 3 i to 3 ij of the *liquor picis alkalinus*.

Of internal treatment Dr. B. speaks at some length; of arsenic he says: "Daily experience proves that arsenic is not a specific for eczema, nor indeed can we reasonably look for any one remedy to cure so polymorphous a disease."— "I feel confident that others who see much of skin diseases will bear me out in the assertion, that arsenic has been very much overrated in its power over cutaneous affections."

Dr. B. lays great stress on the importance of counteracting that state of the systemic processes in which there is a sub-oxidation of the effete matters in the animal fluids, manifested by a hyper-acidity of the eliminations from the blood, viz.: urine, sweat, gastric juice. To meet this difficulty when it exists he advises alkalies in some form or other.

Restoratives generally are to be relied upon, more especially cod liver oil. Sedatives may be resorted to at night, of these Dr.

B. prefers chloral, as it not only induces sleep, but relieves also the itching.

The article will bear careful perusal by those who wish to obtain a brief review of the most reliable means we have at our disposal for the mastery of this the most frequent of all the affections of the skin.

In the course of Dr. MURCHINSON's masterly lectures (8) on the liver, he takes occasion, under the head of lithæmia (lithic acid toxæmia), to allude to the effects on the skin of this state of the blood. After quoting Holland, Garrod, and Fox in support of the fact that eczema, lepra, psoriasis and lichen may arise from lithæmia, Dr. M. says :

" My own experience fully bears out the correctness of their observations, but in many cases these cutaneous diseases appear to arise from the functional derangement of the liver which often precedes gout, although neither the patient or any of his family has ever suffered from this disease."

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## ELECTRO-THERAPEUTICS OF SKIN DISEASES.

THE EDITOR.

1. **Beard, Geo. M.** — The use of electricity in skin diseases. Trans. Am. Med. Association, Vol. 25, 1874, pp. 239-242.

2. **Beard, Geo. M.** — Chronic eczema of legs rapidly relieved and cured (?) by central galvanization. Archives of Dermatology, Oct., 1874, p. 55.

3. **Bulkley, L. D.** — Herpes zoster ophthalmicus successfully treated by electricity. Arch. of Dermatology, Oct., 1874, p. 54.

4. **Cheadle, W. B.** — Acne rosacea treated by local faradization. Practitioner, July, 1874, p. 8.

5. **Deering.** — Use of electricity in scrofulous ulcers. Am. Jour. Med. Sci. (Lancet, Jan. 10, 1874).

6. **Leach, Alonzo.** — Electricity in the treatment of chilblains. Brit. Med. Jour., March 28, 1874.

7. **Mann, E. C.** — Case of elephantiasis Arabum treated by local galvanization. Am. Jour. Syph. & Derm., Oct., 1874, p. 356.

8. **Rockwell, A. D.** — On the relation of electricity to the pain of herpes zoster. Phila. Med. Times, July 25, 1874.

9. **Santopadre.**—Successful use of electricity in chilbl ins. Gaz. Med. Ital. Prov. Ven. (Lancet, Jan. 17, 1874).

While the application of electricity to medicine is becoming daily more and more widely spread, and numerous observers are studying its effects in the most varied diseases, but few results have been recorded during the past year in the field of dermatology, although very many are using this method or treatment, and the literature of the subject will undoubtedly be large ere long.

BEARD (1) thinks that much can be done in *chronic eczema and prurigo by means of central galvanization*, i. e., placing the negative pole at the pit of the stomach and the positive over the head and down the whole length of the spine, and to the sympathetic in the neck, no local application being made. This is illustrated (2) by a case of eczema of the legs of 16 months' standing where rapid relief was obtained by this method, and in another case of Dr. Kinsman's where local galvanization was applied as well. "The moment the current is passed along the spine, the pruritus ceases."

The relief afforded in *herpes zoster* is illustrated by cases by BULKLEY (3) and ROCKWELL (8). The former reports herpes ophthalmicus checked promptly, by a continuous galvanic current from eight cells, the negative pole being placed indifferently on the head, neck and epigastrium, and the positive passed with a moist electrode over the eruption. Rockwell used mild general faradization, every other day with signal success in relieving the pain of zoster. He states that when the eruption is on the head the galvanic current can alone afford relief, but when the body or limbs are affected the faradic is preferable. He also applies the latter locally.

CHEADLE (4) used *faradization in acne rosacea*, applying the negative pole, with a current of medium intensity, slowly over the whole of the affected surface for ten minutes twice a week. Four cases were tried, three of them, after two or three months' treatment, appeared considerably improved and ceased to attend, the fourth was still under observation, had repeatedly improved greatly and, ceasing to attend had relapses in the course of a few weeks. This has been noticed in a case recently under our own care, in a young man, aged 21, where electrical treatment for two months produced a certain amount of change for the better but failed to restore the nose to its normal color, and where the disease

returned on cessation of the treatment. The first effect of the treatment is to cause a bright redness of the parts operated on, and increased sensation of burning. He thinks the results warrant a further trial.

Satisfactory results have been obtained with *electricity in chil-blains* by LEACH (6) and SANTOPADRE (9), the latter using it as follows: The positive pole, with a weak current, is applied a little above the diseased spot, while the negative is moved over the inflamed parts for ten or fifteen minutes. This has been successful in a single sitting but may be repeated daily, if necessary. Four cases are given by S. with good results after the failure of other treatments.

A case of *elephantiasis Arabum* is given by MANN (7) where very striking results are claimed to have followed the use of the galvanic current. "A copper plate, to which was attached the negative pole of the battery, of sixteen cells, was put under the right (affected) leg, which was well moistened with a warm saline solution, and the weight of the body, as far as practicable, rested on this foot. The positive pole was attached to a large sponge and was thoroughly rubbed over the entire surface of the leg and thigh." The leg was reduced from a circumference of twenty-five inches to seventeen inches, in three and one-half months, with applications twice a week during the last month, and very irregularly before. A large ulcer underwent very healthy alteration and nearly healed.

10. **Beard, Geo. M.**—Treatment of nævi by electrolysis. Phila. Med. Times, Sept. 5, 1874, p. 772.

11. **Beard, Geo. M.**—A new method of treating malignant tumors by electrolyzing the base. Arch. of Electrol. and Neurol. May, 1874, p. 74.

12. **Crosby, A. B.**—A case of scirrhus of the rectum treated by electrolysis. Archives of Electrol. and Neurol., May, 1874.

13. **Frommold, Carl.**—Electrolysis and electro-therapeutics. Schmidt's Jahrb., 1874, No. 9, p. 320.

14. **Meyer, Moritz.**—Glandular swellings treated by electricity (*Verkleinerung von Drüseng.*) Berl. Klin. Woch., XI., 10.

15. **Penhall.**—Nævus treated by electrolysis. Lancet, April 11, 1874, p. 530.

The electrolytic action of the galvanic current has received

much attention in the past, and is now a recognized method of treatment in certain conditions. BEARD (10) and PENHALL (15) report cases of *nævi* thus treated with good results. The following is the method adopted by the latter. Two to four needles, connected with the negative pole from twelve to twenty-one cells are passed into the base of the tumor near its center, while the positive pole, with a sponge electrode, is placed somewhere in the neighborhood. The patient being previously anæsthetized, the needles are inserted several times if the *nævus* is large. No hemorrhage follows, no dressing is required, the crust dries and falls in a few days, leaving, in small *nævi*, no mark. Generally but a single sitting is required.

In *malignant tumors* BEARD (11) uses flat spear-shaped needles, the one connected with the positive pole being inserted beneath the tumor and near the border, remaining *in situ* during the operation. A similar needle, connected with the negative pole, is inserted also underneath the tumor, and, if possible, at some distance below the base of the growth, so that the point emerges on the opposite side. The current is now gradually let on, and the strength increased until electrolysis becomes active, as will be indicated by the yellowish foam at the negative pole, which becomes gradually loosened. As the action increases, the negative needle may be slowly worked from side to side, with a slight cutting motion, so as to undermine the tumor. It is often desirable to further work up the base after the tumor falls off.

**16. Bryant, T.**—The value of the galvanic cautery as a caustic, in lupus, epithelial cancer and *nævi*. *Lancet*, April 4, 1874, p. 469.

**17. Dawson, B. F.**—Treatment of vascular *nævi* with the galvanic cautery. *Am. Jour. Obstet.*, May, 1874, p. 137.

**18. Von Bruns, Victor.**—On galvano-cautery (*Zurgalvano-kaustik*). *Deutsche Klinik*, Jan. 3, 1874, p. 1.

Perhaps the most striking results reported during the year in this department are those of BRYANT (16) in the use of *the galvanic cautery in lupus, epithelioma and nævus*. Four cases of lupus are given where a single thorough application of this means resulted in complete cure, six cases of epithelial cancer were similarly treated in four of which but one operation was required, followed by rapid recovery. In one instance there was some recurrence at the end of nine months which was removed in the

same way, and in the other case two minor cauterizations were required subsequently. The patients were under ether, and the porcelain cautery was generally used, or such a one as the case required.

Twelve cases of nævus (out of very many) are recorded, illustrating the facts that simple nævi are to be cauterized from the surface; in the mixed variety they are cauterized and also perforated with heated points; in the sub-cutaneous variety perforated alone, and in one case a mixed nævus was removed as a whole with the *galvanic ecraseur*. Large nævi are to be attacked piece-meal. The eschar should not be disturbed, and on falling the cicatrix is generally white and movable. He regards that there is some new action set up by the galvano-caustic which assists the cure. DAWSON (17) relates several cases of nævus thus treated, and VON BRUNS (18) the same, giving also the application of the galvano-cautery in many other conditions, most of which belong rather to the domain of surgery.

**19. Dreschfeld, Julius.**—On the use of the constant current in spermatorrhœa. *Practitioner*, Nov., 1874.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### THE TREATMENT OF SYPHILIS.

R. W. TAYLOR, M. D.

**1. MacSweeney, Jos. P.**—Iodide of potassium and carbonate of ammonia in syphilis. *Brit. Med. Jour.* Jan. 10, 1874.

**2. Panas.**—Treatment of syphilis by mercurial frictions. *Jour. de Méd. et de chir.*, and *Lond. Med. Rec.* Jan. 7, 1874.

**3. Schuster.**—Treatment of syphilis (*Bemerkungen zur Behand. der Syph.*). Berlin, 1874.

**4. Spender, J. K.**—The treatment of syphilis. *Lancet*, April 25, 1874.

**5. Cotte, L.**—Treatment of syphilis by hypodermic injections of a mercurial salt. *Thése de Paris*, 1873.

**6. Cullingworth, C. J.**—Subcutaneous injection of mercury. *Lancet*. Nos. 19, 20 and 21; 1874.

7. **Le Moaligou.** — Hypodermic injections of corrosive sublimate in the treatment of syphilis (*Des Injections sous-cutanées, etc.*). Thése de Paris, 1873.
8. **Profeta, G.** — Hypodermic injections of mercury in syphilis. Annales de Derm. et de Syph., 1874, No. 4.
9. **Reumont, Alex.** — Treatment of syphilis by mercury and sulphur waters (*Ueber die Behandlung etc.*) Berlin, 1874.
10. **Saint-Paul, A.** — Use of sulphur waters in syphilis (*Etude sur la méd. therm. sulph., etc.*). Thése de Paris, 1873.
11. **Proksch, J. K.** — Anti-mercurial views of the treatment of syphilis. (*Der anti-mercurialismus, etc.*). Erlangen, 1874.
12. **Berry, W.** — Treatment of venereal warts and condylomata. Med. Press and Circular. June 10, 1874.

M. PANAS (2) makes a powerful appeal for the *treatment of syphilis by mercurial frictions*. In contrasting its alleged disadvantages, he thinks that its rapidity and certainty of action far outweigh them. He lays stress on the fact that all mercurial salts are decomposed in the alimentary canal, and that they undergo further disorganization in passing through the liver. This does not occur in the friction treatment, in which the mercury passes immediately into the circulation. He lays down the rule that stomatitis should not be and need not be induced. In order to prevent it, he causes his patients to use a very strong astringent tooth-powder twice or thrice daily, and to have all bad teeth renovated and freed from tartar. During the course he advises a vapor bath bi-weekly, as he thinks, that beside their detergent effect, they are useful in the prevention of ptyalism. Smoking is prohibited, or if indulged in, pipes with very long stems are advised, so that the heated smoke may be less irritating. Panas cites cases which may be looked upon as severe, which have rapidly yielded to this treatment. He thinks that infantile syphilis should be treated with mercurial frictions. The usual quantity advised is ninety grains daily.

In a pamphlet of about sixty pages SCHUSTER (3) gives his views as to the *treatment of syphilis*. His opportunities as physician at Aix-la-Chapelle enable him to speak with authority upon the value of the bath treatment. His work contains nothing new. He administers mercury alone or with the preparations of iodine, using the baths as a supplementary treatment.

In the second stage of syphilis, SPENDER (4) gives mercury and

iodide of potassium together; using ten grains of the latter with a grain and half of grey powder or blue pill, thrice daily. The intermediary squamous syphilides should be treated with the bichloride dissolved in tincture of bark. For the tertiary stage he praises a combination of the iodide with the bichloride of mercury.

Dr. L. COTTE (5) gives the result of his trial of the *hypodermic use of mercury* in twelve cases, adding, however, no new facts. Adopting the treatment in the French eastern military stations in which a chronic diarrhœa is endemic, he found in cases in which this trouble and syphilis co-existed, that the hypodermic method spared the gastro-intestinal tract and thus allowed of internal medication for the diarrhœa, without any disturbance to it by the mercurial. This point is important, and is an exemplification of an advantage of the treatment which has already been claimed for it. In his conclusions he claims a greater range of usefulness for the treatment, we think, than his experience will warrant. His idea that this mode of treating syphilis would be beneficial in infants and children is not founded upon experience and is at variance with our own observation. The solution used by Cotte was the one recommended by Staub.

Though CULLINGWORTH (6) adduces no new facts, it is evident from a perusal of his papers that he has studied the *hypodermic treatment of syphilis* very carefully. He thinks that besides the usual well-known advantages, the method is valuable from its economy and from the fact of the avoidance of that publicity which is incurred by mercurial baths. He does not consider that a final judgment can yet be passed.

This pamphlet of LE MOALIGOU (7) contains nothing new as to the value of the *hypodermic treatment*. The author thinks that Staub's chloro-albuminous solution of mercury is equally as irritating to the integument as any other, and that owing to its rapid decomposition, others are to be preferred. He regards the site of injection advised by Staub, namely: over the gluteal region and upon the thighs, as more frequently attended with discomfort and pain to the patient than that of the dorsal and inter-scapular region.

Dr. G. PROFETA (8) reviews, very impartially, the *hypodermic treatment*, and considers that the indications for its use are in cases of gastric intolerance, in those in which there is a want of success of other methods; and in others where rapidity of action is required.

Residing in Aix-la-Chapelle, REUMONT (9) has had excellent opportunities for observation, and thinks that the treatment by *sulphur waters* is of value to syphilitics, who have taken mercury for longer or shorter periods, particularly those whose nutrition has been lowered by it. When there is a mixed condition such as mercurialization and syphilis or a co-existence of syphilis and gout, the baths are of value as a preparatory means of treatment. Reumont also thinks that a combination of specific treatment and the use of the waters is of benefit in constitutional syphilis. He advances no new ideas as to the mode of action of the waters, and calls attention to the fact, that a thermal course often causes the outburst typical lesions of syphilis in cases in which the diagnosis is doubtful. He devotes considerable space to discussing the natural history of syphilis. Contributions of a practical character like this one, are of benefit as suggesting, that perhaps in our country we may adopt a course which is of benefit when the ordinary treatments fail.

Internally and externally sulphur waters are regarded by SAINT PAUL (10) as a valuable adjuvant to a mercurial treatment; not beneficial, however, without a previous or synchronous mercurial course. The various theories as to the mode of action of the waters are discussed; but, as usual, the author does not arrive at any very satisfactory conclusion. The directions for the treatment are clearly and briefly given.

J. K. PROKSCH (11), in a somewhat extensive work, considers at length the various views as to the therapeutics of syphilis from the earliest time to the present day. He is a decided anti-mercurialist, and sums up his conclusions, which he endeavors to support by argument as follows: 1. Mercury is not an antidote to the syphilitic poison. It merely causes the more rapid disappearance of some of its lesions or symptoms. 2. We do not know the effect of mercury or even of syphilis. 3. Syphilis is cured by the healing power of nature alone, assisted by a simple topical, symptomatic and dietetic treatment. 4. During a mercurial treatment the study of the pathology of syphilis is impossible. 5. Mercury employed in hospitals for syphilis favors the development of scrofula and gangrene, and is injurious to such patients by its vapors.

Dr. W. BERRY (12) recommends the careful and thorough application of acid nitrate of mercury to each venereal wart, the surrounding parts being covered and protected by a little olive oil. Two applications have cured cases upon which other agents had failed.

## INFANTILE AND CONGENITAL SYPHILIS.

FRED. R. STURGIS, M. D.

1. **Ballard.**—Value of signs and symptoms regarded as diagnostic of congenital syphilis in the infant. 8vo pp., 23; J. & A. Churchill, 1874.
2. **Bryant.**—Hereditary syphilis. Variola in mother. Escape of child after vaccination. Syphilitic father. Mother free from symptoms. — Med. Times and Gazette, May 2, 1874.
3. **Bryant.**—Hereditary syphilis in twin children. Mother free from symptoms. Poison inherited from the father. Ibid.
4. **Bulkley, L. D.**—Rare cases of congenital syphilis. — (*Dactylitis syphilitica.*) N. Y. Medical Journal, May, 1874.
5. **Busey, S. C.**—Dactylitis syphilitica in a child eighteen months old. Am. Journ. Med. Sciences, Oct., 1874.
6. **Gressant, J.**—The later manifestations of hereditary syphilis. (*Des manifestations tardives, etc.*) Thèse de Paris, 1874.
7. **Kjellberg.**—Case of hereditary syphilis. (*Fall von hereditärer syphilis.*) Hygeia XXXVI, 5. Sv. läkaresällsk fösh, 1874.
8. **Madier Champvermeil, Ch.**—Palmar and plantar syphilides, especially those of hereditary syphilis. (*Des syphilides palmaires et plantaires, etc.*) Thèse de Paris, 1874.
9. **Parrot.**—Rachitis of syphilitic origin. Gaz. Med. de Paris, No. 14, 1874, and Gior. Ital. delle Mal. Ven. e. della Pelle, April, 1874.
10. **Poucet.**—Lesions of the bones in infantile syphilis. (*Syphilis infantile, etc.*) Bull. d. l. Soc. Anatom. de Paris, 1874.
11. **Sparks, E. J.**—Ulcerating syphilis in a child twelve years old. London Lancet, June 20, 1874.
12. **Taylor, R. W.**—Syphilitic lesions of the osseous system in infants and young children. Am. Journ. Obst., May, 1874.
13. **Taylor, W. T.**—Congenital syphilis in six successive infants. Am. Journ. Obstet., Feb., 1874.
14. **Thiry.**—Infantile syphilis. (*La syphilis infantile.*) La Presse Med. Belge, 1874, V. XXVI.
15. **Violet.**—Practical treatise on infantile syphilis. (*Etude pratique de la syphilis infantile.*) Thèse de Paris, 1874.

16. **Woronochin.**—Rare cases of hereditary syphilis. (*Seltenen Fälle v. hereditärer Syphilis.*) Jahrb. f. Kinderheilk., 1874, v. 8.

BRYANT's cases (2 and 3) are only noticeable for the fact that the history of the parent's condition seems to have been accepted from the persons themselves, and not from examination.

These cases of *congenital syphilis* by Dr. BULKLEY (4) are interesting from one point of view, if from no other, that they show the possibility of a *dactylitis* occurring from an entirely non-specific cause.

In the third of his cases, as he states, the origin was certainly not due to syphilis, so far as an absence of any symptoms in father, mother or child could place it. He also calls attention to one or two points which may, perhaps, be of value in determining the differential diagnosis between the specific and non-specific lesions of the hands in children; first, the fact that the little finger was the seat of disease, this being rarely attacked in syphilis. Second, the fact that the ulceration was seated upon the ulnar side of the finger, and third, that the lesion did not appear until the child was sixteen months old.

In the other two cases, the cause was certainly syphilitic in one, probably in the other. The bones attacked were the thumb and forefinger of the left hand, the middle of first metacarpal bone of the right, the fourth and fifth metatarsal bones of the left foot and the external malleolus of the right foot in the first of the narrated cases, and the first phalanx of the right thumb in the second case. Two of the cases are represented by wood-cuts.

These cases are a valuable contribution to our literature of the subject.

CHAMPVERMEIL (8) very properly refutes the idea that the squamous syphilides the only manifestations of syphilis which appear upon the palms of the hands and soles of the feet, and shows from his own and others' experience that other forms exist. He divides his subject into a review of the acquired and hereditary forms, and to this latter variety we shall more especially call attention. This he classifies as follows: The hyperæmic syphilides, which comprises erythema simplex, and the neoplastic syphilides, including the squamous, bullous and ulcerating erythema, and as a species of the bullous variety he ranks pemphigus.

The bullous variety he regards as a graver symptom than the squamous or simple erythema, and pemphigus as a more

advanced stage, of which the bullous forms the initial step. As to the vexed question of the difference between pemphigus simplex and pemphigus syphilitica, our author agrees with M. Roger's views which may be briefly stated as follows: pemphigus simplex is seated indifferently over the body; the bullæ are round, varying from three to twelve in number, contain a citron-colored serum, and are rare before the third month of life, while pemphigus syphilitica is generally confined to the hands and feet, is confluent and composed of numerous irregularly-shaped bullæ, containing a sanguineous or purulent fluid, is congenital, and usually appears during the first few days of life.

Dr. R. W. TAYLOR's (12) contributions are reserved until their completion in book form.

Dr. W. T. TAYLOR (13) gives the history of a woman, married in 1866, who gave birth to two children, apparently syphilitic, previously having had four miscarriages, the first at  $5\frac{1}{2}$  months, the second at 6 months, the third at 7 and the fourth at 8. The two living children were the fifth and sixth; of these two, the first one was attacked with bullæ on the feet and body when three weeks old, and finally succumbed when eight weeks of age, to diarrhœa.

Dr. T. saw the woman in the seventh month of her sixth pregnancy, and at once instituted a treatment of the bi-chloride of mercury and iodide of potassium in syrup of sarsaparilla. The child, born at full term, showed no evidences of disease till it was two weeks old, when it was attacked with an excoriation of the skin on the neck, pustules on the palms of the hands and soles of the feet which extended to the thighs and nates. A similar eruption appeared about the mouth. No coryza was observed. In spite of mercurial treatment, the child died in a few days with diarrhœa and vomiting. The mother, as usual, is reported as perfectly healthy, whether from examination and observation is not told, and curiously enough, the father denies ever having had syphilis, but, inasmuch as he was "a gay and festive youth," whatever that may mean, Dr. T. will not excuse him on any such lame ground as a mere denial, and considers *him* as the origin of the baby's disease. Perhaps he was; but why deny the father what is freely allowed the mother? Dr. Taylor's practice is far better than his theory, and he very properly treated the mother, the probable true cause of the trouble.

In the discussion which followed the report of the case, Dr.

Parry is made to say that "pemphigus in a syphilitic child does not occur unless associated with coryza." Although often found together, the statement is too sweeping to be correct.

VIOLET (15) divides his thesis into two heads, viz. : acquired and congenital syphilis. Under the former head he reviews the causes, symptoms, diagnosis, prognosis, treatment and medico-legal aspects of the disease. Speaking of causes, he denies *in toto*, the possibility of infection during the passage through the mother's genitals. Such cases are very hypothetical, and on this point he has more grounds for doubt than when he denies the possibility of the infant contracting ophthalmia in the same manner.

The symptoms of the acquired type he regards as identical with those of the congenital, except that the latter are graver and more serious, an opinion, by the way, which would admit of some discussion. The prognosis he considers good in the majority of cases, stating that the age at which the disease is best withstood is between the years of five and ten.

In the treatment of the acquired form, our author ignores completely the use of mercury in powders or by inunction, both of which are as efficacious and more convenient than the internal method he advises, and we must confess to surprise in noticing that he recommends the absurd method of treating the infant by so-called mercurialization of the nurse's milk, an error which we had supposed sufficiently refuted by the experiments of his countryman, M. Cullerier. Under the second head, there is very little to be noted. The author adheres, among other causes, to the father being the sole cause of the disease in the child, and gives a case which is by no means convincing. He founds his belief, he says, upon theory and his one case — the former of which is fallacious and the latter dubious.

Under infection through the mother, he reviews the question as to the time of the mother's infection ; whether before or during pregnancy, and inclines to believe that if the infection occurs during the latter part of pregnancy, the child escapes. He likewise speculates upon the possibility of the mother's disease being dependent upon contamination by the foetus from the father, giving an example from M. Dieulafoy's *Thèse d' Aggrégation*, 1872, and which he very properly criticises.

Before closing this review, let us give him credit for mentioning, under the head of congenital syphilis, the good results derived from inunction, which is marred, however, by the proposition to

treat the infant by mercurialized goat's and woman's milk. It is also noteworthy, that while discussing the etiology of infantile syphilis, he entirely ignores the writings of Oewhre, Mireux, Charrier, and Cullerier.

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## SYPHILITIC DISEASES OF THE EYE AND EAR.

CHARLES S. BULL, M. D.

1. **Anstie.**—Diplopia and ptosis with syphilitic paralysis and muscular atrophy. *Transactions of the Clinical Society*, VI, 1873.
2. **Bull, C. S.**—Two cases of interesting syphilitic lesion of the eye. *Trans. Am. Ophthalmolog. Soc.*, 1874.
3. **Förster.**—Choroiditis syphilitica. *Archiv für Ophthalmologie*, XX. 1.
4. **Fournier.**—Triple ocular paralysis of syphilitic origin. (*Triple paralysie oculaire.*) *An. de Derm. et de Syph.* Tome 5, No. 3.
5. **Pirrochi and Porlezza.**—Mydriasis syphilitica. *Giornale Italiano delle Mal Ven. e del. Mal della Pelle.*
6. **Sinclair, A. G.**—*Irido-cyclitis syphilitica.* *Peninsular Journal of Medicine*, November, 1874.
7. **Sturgis, F. R.**—Clinical records of syphilitic affections of the eye. *Archives of Dermatology*, Oct., 1874, p. 57.

ANSTIE (1) reports a case of a man, 32 years old, the subject of syphilitic disease, who one morning noticed a sudden *diplopia* and *complete ptosis* of the left upper lid, which improved under the iodide of potassium. In the following February, he was attacked by sudden pain and extremely rapid loss of power and substance in the right arm. By June, the triceps and flexors were atrophied to a few threads. By the use of the iodide of potassium and faradization, the muscles regained their size and strength in four weeks.

FÖRSTER (3) publishes an interesting clinical paper on the subject of *choroiditis syphilitica* though there is nothing new in it. He speaks of subjective appearances of light of a fixed character, as a constant symptom. They consist of bright, transparent spots, disks or rings, and oval figures, numerous and constantly shifting their position. This *photopsia* is definitely connected with defects

in the visual field. Another constant symptom is hemeralopia. Another not uncommon symptom is *micropsia*. In this affection the accommodation is generally limited. Though defects in the visual field are very common, positive scotomata are generally absent. Förster is very non-committal upon the changes which the diseased eye undergoes in refraction, except that he has never observed a hyperopia developed. The complication with iritis is not uncommon, and it is always of the plastic variety. Förster thinks that the choroid is always first and most severely affected, and afterward the retina, and as proof of this he mentions: 1st. The complication with iritis. 2d. The hemeralopia, which is wanting in affections of the anterior layers of the retina and optic nerve. 3d. The opacity of the vitreous. 4th. The diminution of the accommodation. 5th. The changes in the choroid and retina, which can only come from a preceding choroiditis. The disease shows a great tendency to recur. As regards results, a complete restoration is only obtained, when the case is not serious, shows no considerable defects and was treated from the beginning. The best results were gained by mercurial inunction pushed to beginning ptyalism and in a dark room, followed, after a few days, by the iodide of potassium.

FOURNIER (4) publishes an interesting case of *syphilitic paralysis of the third and sixth nerves of the right eye with paralysis of the sixth nerve of the left eye*. The patient had contracted the primary lesion four years before, and this was followed by most of the constitutional symptoms. About three years after this he was attacked by violent headache, accompanied by temporary diplopia, which soon became constant. Soon after this, the right upper lid commenced to droop. An examination showed in the right eye a paralysis of the external rectus, internal rectus, superior and inferior recti, and inferior oblique, and paralysis of the levator palpebræ superioris. The globe was absolutely immovable, the pupil was dilated, but vision was normal. In the left eye there was paralysis of the external rectus and slight convergent squint, owing to subsequent contraction of the internal rectus. There was no cutaneous lesion, no headache, and no glandular enlargement. The patient was treated for two months by mercurial inunction and syrup of the iodide of potassium, and sulphur baths, and was completely cured.

PASQUALE PIROCCHI and PORLEZZA (5) report a case of *syphilitic mydriasis* in a man, 40 years of age, who contracted the primary

lesion in 1860, and had no specific treatment for the disease. In February, 1872, he began to be troubled with a continuous sense of pain over the right eyebrow, followed by mydriasis, failure of vision, diplopia and photophobia. He had no other symptom of syphilis and no other ocular lesion. Hence a diagnosis was made of incomplete paralysis, and the cause was localized at the motor branch of the ophthalmic ganglion, and was probably a syphilitic neoplasm. The patient was cured in a month by the protiodide of mercury and iodide of potassium. The authors exclude any lesion of the sympathetic.

SINCLAIR (6) reports a case of *irido-cyclitis* in a negro, following seven or eight months after the primary lesion. It commenced as an iritis of one eye, which involved the cornea and ciliary body, and very soon afterward the same process commenced in the fellow eye. The treatment by mercurial inunction, local depletion and atropine was carefully carried out, and was followed by a temporary improvement in the right eye. The inflammatory process, however, returned; abscesses were formed in iris and ciliary body; the left eye developed an enormous corneal staphyloma, and enucleation became necessary. A microscopic examination revealed the whole iris, choroid and ciliary body, as well as the sclera, infiltrated by small cells, probably of a nucleated, granular texture, resembling the cells of gummata. The case illustrates the virulent character assumed by the syphilitic disease in the colored race.

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## SYPHILIS OF THE MOUTH, THROAT AND LARYNX

GEO. M. LEFFERTS, M. D.

1. **Baumler.**—Syphilis of the nares, larynx, trachea and bronchia (*Syphilis der nasenhöhle, kehlkopf, trachea, etc.*) Ziemssen, Hand. der Spec. Ther. u Path., Leipz., 1874, pp. 196-200. Band III.
2. **Bucquoy.**—Syphilitic angina (*De la angine syphilitique*). La France Méd., No. 26, 1874.
3. **Elsberg, Louis.**—Syphilitic membranoid occlusion of the rima glottidis. Am. Jour. of Syph. and Derm., January, 1874.
4. **Fournier, A.**—Tertiary syphilis of the palate (*Syphilides tertiaries du voile du palais.*) Mouv. Méd., Nos. 26, 27, 29.
5. **Fournier, A.**—Tertiary syphilitic affections of the tongue. Gaz. Hebdom, Sept. 11, 1874; Phil. Med. Times, Oct. 10, p. 25.

6. **Fournier, A.**—Tertiary syphilis of the pharynx (*Des lesions tertiaires du pharynx*). Annal. de Derm. et de Syph., T. V., No. 6.
7. **Homolle.**—Supposed syphilitic papilloma of the pharyngolaryngeal mucous membrane (*Papillome d'origine probablement syphilitique, etc.*) Bull. de la Soc. Anat. de Paris, 1874, p. 115.
8. **Kaposi, Moriz.**—Chancres of lips and tongue; delineations. Die Syphilis der Haut und der angrenzenden Schleimhäute. 1 Lief. Wein, 1873, Taf. 13, figs. 1, 2 and 3.
9. **Kaposi, Moriz.**—Syphilitic rhagades of the mouth. (Die Syph. der Haut, etc.) 2 Lief. Wien, 1874, Taf. 36, fig. 1.
10. **Machou, H.**—Tertiary syphilitic pharyngitis (*De la pharyngite syphilitique tertiaire*). Paris, 1874, 8 vo., pp. 38.
11. **McBurney, C.**—Syphilitic contraction of pharynx. (Trans. N. Y. Laryngolog. Soc.) N. Y. Medical Jour., July, 1874, p. 83.
12. **Pick.**—Syphilitic affections of the mouth and larynx. Böhm Corr. Blatt, Bd. 2, No. 10, p. 4.
13. **Ricord, M.**—Syphilis of the tongue (*Des affections syphilitiques de la langue*). Union Méd., p. 753.
14. **Schrotter, L.**—Syphilitic affections of the larynx (*Veränd. im Larynx bei syphilis*). Laryngolog. Mittheil. Wein, '74, p. 75-83.
15. **Smith, A. H.**—Syphilitic laryngitis; crico-arytenoid ankylosis; gummy tumor at root of neck compressing left bronchus; partial recovery. Virg. Med. Mon. June, 1874, p. 139.
16. **Thierfelder, A.**—Syphilis of the larynx, microscopic anatomy of. Atlas der Path. Histol., Leipzig, 1872, I Lief., Taf. 2, figs. 1 and 2.
17. **Thierfelder, A.**—Syphilitic infiltration of mucous membrane of mouth, microscopic anatomy. Atlas der Path. Anat. Leipzig, 1873, II Lief., Taf. 8, fig. 3.
18. **Thornton.**—Syphilitic narrowing of the trachea. Path. Soc. of London. Lancet, June 13, 1874, p. 837.

FOURNIER (4) divides *syphilitic lesions of the palate* into ulcerative syphilides, or those in which ulceration constitutes the essential and primary clinical phenomenon, and into gummy syphilides. He does not dwell upon the first form, which is rather rare and which affords nothing of special interest; but the history of the gummy tumors of the velum presents several interesting points, to which he desires to call attention. At its commencement, the gummy tumor has a rounded aspect and the general shape of a

pea or almond; but the lesion rapidly extends, and the form most frequently seen is that of a diffused tumefaction, involving the greater part of the velum. This latter is thickened, hard, resisting, rigid and inert throughout all its affected parts. There is no distinct, isolated, demonstrable swelling; but the tissue proper of the velum is generally tumefied. The lesion is indolent, almost latent, and does not trouble the patient; later on it suddenly softens and disappears in a few days, leaving at its site an ulceration as extensive as the original lesion. It is upon this indolent character and the sudden softening that Fournier especially insists. He describes, then, the different forms which the ulceration may present and its extensions toward the pharynx.

The functional troubles produced by the loss of substance are the alteration of the voice, the nasal regurgitation of fluids and, more rarely, impairment of hearing, ptyalism and pain. This latter does not occur in the primary period, but may assume great intensity in the third. The author states that the absence of ganglionic engorgement is the rule, and that the lesion causes no marked general symptomatic reaction. These lesions can only be confounded with scrofulous ulcerations; but an attentive study of the antecedents, of the progress of the ulceration and the treatment, will generally give positive indications as to character. The treatment should consist in large doses of the iodide of potash and in the use of ioduretted gargles. Caustics are injurious.

MACHOU (10) states that the *tertiary syphilitic pharyngitis* is characterized. 1st. By a hypergenesis of the connective tissue which enters into the structure of the soft parts of the pharynx. 2d. By the formation of neoplasms or gummy tumors, these being easily recognizable from their general aspect, their form and location, their mode of development and of termination, the latter either by reabsorption or ulceration. 3d. By ulcers consecutive to the primary lesions, having elevated edges, of a copper red color and with grayish and irregular bases.

The surrounding mucous membrane is more or less reddened and is always hard and thickened. The extension of the process to the nasal fossæ, to perforation of the palate, with the corresponding ganglionic engorgement, generally occurs. Pain develops, with the period of ulceration; dysphagia, dryness of the throat, nasal tones, reflux of fluids, ozæna, deafness and more or less complete abolition of taste are the principal symptoms. There is

rarely a complete cure, but commonly a narrowing or atresia of the palato-pharyngeal tract.

M. RICORD (13) gives the indications which aid in the formation of a correct diagnosis in several of the *syphilitic affections of the tongue*. He has never seen the soft chancre of the tongue, but he does not say that it cannot exist. The indurated chancre has often been confounded with the chancroid, when at about the end of three weeks it has acquired its full development, moreover the progress of the chancre is slow and has an indolent character while that of the chancroid is painful and its progress is more rapid. The condition of the ganglia alone can in difficult cases assure the diagnosis. If there be a tuberculated induration of the tongue, accompanied by an early engorgement of the lymphatics without suppuration, it is syphilis.

A frequent form of the secondary manifestations on the tongue is characterized by spots resembling those of roseola, they are red and rounded, are followed by a rapid desquamation of the epithelium, and never pass the pillars of the fauces. The resulting papules and the mucous patches have often been confounded with mercurial erythema. This latter however is accompanied by a foetid odor and a general swelling of the mucous membrane, and the special point to which the author directs attention is, that the mercurial stomatitis always has its point of origin at some one place where the membrane has been irritated by the presence of a carious tooth, or at a fissure irritated or caused by a foul pipe. The first fact is so true that in infants, without teeth, he states that there is never a mercurial stomatitis. The gummata may be confounded with the chancroid, they differ however from it in their number, always being multiple, whereas the chancroid is single and by the complete absence of ganglionic enlargement, while the chancroid is accompanied by induration of the glands, when it arrives at the period of ulceration.

SCHRÖTTER (14) in a short but well written and interesting chapter, gives the result of his observations upon one hundred and forty cases of *syphilitic disease of the larynx*, adding the full histories of a number of the most interesting cases.

The diagnosis of the affection was partly made from the laryngoscopic appearances, aided by the clinical history of the patient, the concomitant appearances of the disease in the pharynx and mouth and the symptoms of general syphilis. A diagnosis from the laryngoscopic picture alone can only be made when ulceration

exists. A syphilitic laryngeal catarrh presenting no diagnostic appearances. He admits that some of the above aids to diagnosis were in many cases unreliable, owing to the lapse of time and the inability of the patient to give a clear history, and generally he was obliged to depend upon the pharyngeal appearances and a careful examination of the patient's whole body.

He states that in every case of ulceration of the larynx or of the mucous membrane of the mouth and pharynx, when other diseases, especially tuberculosis, could not be clearly diagnosed, syphilis was considered to be the cause, especially as he holds that the occurrence of pure, wide spreading catarrhal ulcerations, in otherwise healthy subjects, is not demonstrable.

The laryngeal ulcerations were found most commonly to be deep and wide spread throughout the larynx, and next in order of frequency they appeared upon the epiglottis alone, then in the posterior commissure and lastly upon both vocal cords. Isolated ulcerations upon the ary-epiglottic folds were rarely observed.

The cases were generally treated by the combined method, viz.: The laryngeal catarrh by appropriate inhalations, the ulcerations with iodine and glycerine or cauterized with the nitrate of silver, and at the same time the administration of iodide of potash or the use of mercurial inunctions; in certain cases the two latter being employed simultaneously.

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## GONORRHŒA AND ITS COMPLICATIONS.

R. F. WEIR, M. D.

1. **Beauvais.**—Parasitic balano-posthitis in diabetes mellitus (*De la balano-posthite dans la glycosurie*). *Gaz. Méd. de Paris*, No. 18, 1874.

2. **Bredin, J. N.**—Hydrastin in Gonorrhœa. *Phil. Med. Times*, Sept. 12, 1874.

3. **Ferrand.**—Best method of giving cubeb and the oleo-resins in gonorrhœa. *France Médicale*, April 11, 1874.

4. **Gazeau.**—Sulphate of cadmium in acute gonorrhœa. *Bull. Gen. de Thérap.*, 15 May, 1874.

5. **Godon, F. W.**—Abortive treatment of gonorrhœa in the male by injections of clay earth. *Am. Jour. Syph.*, Oct., 1874.

6. **Iaschtschenko.** — Urethral blenorragia and phymosis treated by interrupted electrical currents (*Du traitement de la blenorragie uréthrale, etc.*). Centralblatt f. Chirurgie, 1874, p. 4.

7. **Lamarre.** — Treatment of gonorrhœa with hashish and benzoic acid. An. de Derm. et de Syph., Tom. V, No. 5.

8. **Martin-Damourette.** — Bromide of potassium in gonorrhœa. Lancet, Jan. 3, 1874.

9. **Morrison.** — Umbilical gonorrhœa. Bull. Med. du Nord., No. 10, 1874.

10. **Nystrom, A.** — Balano-posthitis, its relations to chancre and its radical treatment. An. de Derm. et de Syph., Vol. V, No. 5.

11. **Pirovano, F.** — Urethral blenorragia treated with injections of hydrate of chloral. Giorn. Ital. delle Mal. Ven. e della Pelle, Aug., 1874.

12. **Libermann.** — Gonorrhœal rheumatism of the larynx (*Tripper rheumatismus des larynx*). L'Union Médicale, 151, 153.

*Balano-posthitis* may occur in *diabetes mellitus* from the fermentation of the urine bathing the glans. Phymosis is to be avoided, as this is likely to be followed by gangrene, of which BEAUVAINS (1) gives a case. Microscopic examination of the pus would determine the presence or absence of the spores of the fungi producing the fermentation. This irritation from glycosuria is produced not only in the male, but in the female, in the vestibule and adjoining regions, and gives rise to annoying itching.

BREDIN (2) uses, after a saline aperient, the following injection: Rx Hydrastin, 3 i; sol. morph. Magendie, 3 ij; mucil. gum acac., 3 iv. M. To be used three times a day.

FERRAND (3) does not use injections, but administers cubebs and the oleo-resins, of the former one gramme every hour. Duration of treatment 20 to 25 days, and by it he says that he avoids the occurrence of gleet.

GAZEAU (4) uses *sulphate of cadmium* as an injection in acute gonorrhœa, one part to 1,000 or 1,800 of water, injected every two hours. The duration of the disease under this treatment is from 15 to 20 days. For gleet he adds sub-nitrate of bismuth to the cadmium solution.

GODON (5) gives 35 cases of acute gonorrhœa treated with *clay earth injections*, as suggested by Dr. Addinell Hewson, of Philadelphia. He injects two and a half ( $2\frac{1}{2}$ ) drachms of the earth mix-

ture, retaining it in the urethra about a minute, using it every four hours. The average duration of the disease after treatment was commenced was between five and six days.

LAMARRE (7) uses the following in gonorrhœa: Rx Tinct. hashish, 2 grs.; benzoic acid, 1 gr., in gum mixture, to be taken in 24 hours; using also injections of simple water frequently repeated.

This was, however, tried in 20 cases by another surgeon, and in only three was the treatment successful, and in but two of these remarkably so.

MARTIN-DAMOURETTE (8) administers daily from 60 to 80 grains of *bromide of potassium in gonorrhœa*, sometimes combined with tincture of digitalis, which latter is especially serviceable in painful erections.

A young man, aged 19, was found by MORRISON (9) to have *urethral gonorrhœa*, and at the same time a similar discharge from the umbilicus, which was relieved by solutions of acetate of lead and sulphate of zinc.

NYSTRÖM (10) thinks that this *blenorhœa of the glans* should be considered as an eczematous affection, dependent on constitutional as well as external causes; the constitutional cause, *i. e.*, rheumatic, scrofulous or herpetic, existing in two-thirds of his cases. In the non-gonorrhœal case the disease generally begins on the internal surface of the prepuce, in little circumscribed spots, and propagates itself thence to the glans, probably by the contact of the opposed inflamed preputial surface. The odor of the altered secretions is very marked, and sceminal emissions are frequent. Adhesions of the prepuce to the glans with contraction of the preputial orifice are often the result of this inflammation.

Balano-posthitis is not only annoying, but is, according to Nyström, the means of entrance of the syphilitic virus, and he accounts for the common situations of chancre and chancroids about the corona glandis by the frequently existing erosions from the disease in question, and from the fact that the epithelium when thus soaked, tears easily.

He considers the amount of the induration of a chancre to be dependent upon the previous existence or non-existence of a balano-posthitis.

He finds the greatest success in treating such cases in the use of powdered tannin dusted daily over the affected surfaces. No

lint or charpie is to be interposed between the affected surfaces, and only where phymosis exists does he use the tannin in solution in glycerine, and then it is applied with a camels-hair brush. The tannin application is to be repeated in a few days, and again a third time in about fifteen days. To prevent relapse it is well to use it about once a month. Constitutional remedies are also advised if a diathesis is present.

The injection of hydrate chloral, one part to 100 of water, two or three times a day, *in gonorrhœa*, has in PIROVANO's hands (11) succeeded in an encouraging manner (as in Parona's, who advised it in 1870). Its antiseptic properties have been elsewhere set forth in an article by Dr. W. W. Keen, of Philadelphia.

LIBERMANN (12) reports a case of *gonorrhœal rheumatism of the larynx*. A soldier having had a slight attack of ordinary rheumatism in 1872, was, on April 28, 1873, the subject of a gonorrhœa, which, on May 15, suddenly stopped and immediately after he had severe pain, without swelling, of the shoulder and knee joints. Three or four days after, he had severe pain in the region of the larynx, followed by complete aphonia. May 21 he entered the hospital. Laryngoscopy showed a considerable swelling in the region of the arytenoid articulation. By the sound, fluctuation was detected in this location. The overlying mucous membrane was congested only over this special cartilage. The left vocal cord was somewhat stretched and did not approximate to the median line in phonation. No disease of the thorax existed, and the patient never had had syphilis. The diagnosis of gonorrhœal rheumatism of the ary-cricodeal joint was arrived at. The treatment consisted in the local application by brush of equal parts of tinct. iodine and tinct. opium. In a single day the pain abated and voice rapidly came back, and patient was discharged cured June 30.

The author makes the diagnosis by: 1. A sharp circumscribed pain in the larynx. 2. Congestion and swelling of the mucous membrane in a limited spot. 3. The feeling of fluctuation over the affected joint. 4. The characteristic monoarticular form of the affection. He remarks further that chondritis or perichondritis would not have subsided so rapidly.

13. Amory, M.—Electrolysis in strictures of the urethra. Archives Méd. Belges, November, 1874, p. 301.

14. **Logan, S.**—Divulsion in stricture of the urethra. New Orleans, Med. and Surg. Jour., July, 1874.

15. **Newman, R.**—Electrolysis in the treatment of stricture of the urethra. Archives of Electrol. and Neurol., May, 1874.

16. **Otis, F. N.**—Instrument for determining the calibre of the urethra at any given point. Lancet, July 11, 1874.

17. **Teevan.**—Impassable stricture of urethra treated by caustic. Lancet, February 7, 1874.

18. **Teevan.**—Catheter urethrotome with conducting bougie. Lancet, May 23, 1874.

19. **Vanderveer, A.**—Report of twenty cases of stricture of the male urethra. Am. Jour. Med. Sci., July, 1874.

LOGAN (14) reports nine cases of *stricture treated by divulsion* with Holt's instrument, in one hundred treated by dilatation and internal urethrotomy. He objects to internal urethrotomy, because; 1. of the unnecessary amount of injury inflicted; 2. because it is a more difficult operation; 3. because the cutting operation is apt to give rise to more hemorrhage. He says, also, that in divulsion there is less liability to infiltration of urine; and he advises the urine to be drawn off with a catheter for two or three days after the operation, but the catheter is not to be left in. After four or five days have elapsed, he begins gradual dilatation.

NEWMAN (15) gives thirteen cases of *stricture treated by electrolysis*, in which he states the cure was permanent; that is, the trouble had not returned at the expiration of fifteen months.

TEEVAN (17). The retention which existed was treated by ice introduced into the rectum, according to Cazenave's (of Bordeaux) plan. The stricture was successfully relieved by three applications of caustic potassa. Teevan considers caustic applicable to impassable strictures in order to open them up so as to subsequently pass a bougie.

TEEVAN'S *catheter urethrotome with conducting bougie* (18) consists of a tunneled grooved catheter, with a slightly modified Maisonneuve's blade.

VANDERVEER (19) states that dilatation is the best and safest method of treatment of stricture. He uses soft olive pointed bougies until number seven or eight (English) is reached, and then metallic sounds. Dilatation must be kept up for years at intervals. When, in strictures of small calibre, it is only possible to introduce

a whalebone guide, he uses divulsion, in the membranous portion and internal urethrotomy, in the spongy portion. Strictures of the spongy portion do not bear dilatation well.

20. **Calvo, Dominique.** — Treatment of the complications of blenorragia. *La France Médicale*, November 11 and 18, 1874.

21. **Fenger.** — Endoscope in chronic gonorrhœa (*Nordisk Medicinskt.*). *Brit. and For. Med. Chir. Rev.*, July, 1874.

22. **Grunfeld, I.** — Endoscopic examination of the urethra and bladder. *Wien. Med. Presse*, Nov. 11, 1874.

23. **Haindy, Aissa.** — Circumcision (*De la circoncision*). *Le Progrès Médical*, April 25, 1874.

24. **Handvogel.** — Orlotomy (*Traitemenit des affections du prépuce par l'orlatomy*). *Le Progrès Médical*, April 25, 1874.

25. **Letenneur.** — Circumcision (*A propos de la circoncision*). 8vo., pp. 48. Paris, 1874. *Le Progrès Médical*, October 17, 1874.

26. **Schwartz.** — Urethro-rectal fistula from prostatic abscess, *L'Union Médicale*, July 2, 1874.

A paper of Dr. FENGER (21) describes the various *affections accompanying chronic gonorrhœa*, which he has observed by the endoscope; they are, superficial inflammation of the mucous membrane in the posterior part of urethra, parenchymatous and hyper-plastic local urethritis, condylomata, polypi, primary syphilitic ulcer and secondary syphilitic eruptions (the last of very rare occurrence).

GRUNFELD (22) uses a laryngoscopic mirror to reflect light into an *endoscopic tube* with a glass plate set obliquely into the distal end like that of Fenger. Application of remedies to the diseased parts does not seem to be as easily made as by the endoscopic tube of Desormeaux.

HAINDY's treatise, entitled *De la circoncision* (23), gives a case of sterility dependent on phymosis and also one of irritation of the bladder, simulating calculus from the same cause.

*Orlatomy or circumcision* from the Hebrew *orla*, signifying prepuce, is practiced by Dr. HANDVOGEL (24) by means of a fenestrated forceps with a triangular blade, which glides along the slit in the forceps like the blade of a tonsillotome.

27. **Brambella.** — Orchitis treated by Furani's method. (*Gaz. Lombard*) *Brit. and For. Med. Chir. Rev.*, July, 1874.

28. **Felippe.**—*Neuralgia of testis cured by electricity.* Lancet, Jan. 3, 1874.

29. **Marsh, H.**—*Novel disease of the penis.* N. Y. Med. Jour., Sept., 1874.

30. **Mears, J. S.**—*Epithelial cancer from male urethra.* Phil. Med. Times, Nov. 7, 1874.

31. **Andant and Lonstalot.**—*Extraction of foreign body from the urethra.* (Bull. de Thérap.) Lancet, May 23, 1874.

BRAMBELLA (27) gives 21 cases of *orchitis treated by Furani's method*, which consists of absolute rest. The patients suffered, some from blenorragic, some from idiopathic, and others from traumatic orchitis. In 12 cases the cause was blenorragia. In 16 the right and in 6 the left testicle was affected. The cure averaged 10 days; once it took twenty-four days.

He compares these results with the known statistics of the time in the cure of orchitis, and draws the following conclusions: 1. That orchitis (epididymitis) gets well spontaneously, and much quicker and better than by the use of medicaments and artificial aids. 2. That art must assist nature by giving absolute rest to the affected organs.

FELIPPE (28) reports a case of *neuralgia of the testis* cured by electricity. It was not due to any disease of the testis, or to fœcal accumulation, and was removed after five applications of a weak and direct constant current.

MARSH (29) gives three cases of his own and two of Prescott Hewitt's, similar to those given to the profession by Drs. Van Buren and Keyes, with the name, *a novel disease of the penis* (N. Y. Med. Jour., April, 1874), which was first noticed by Johnston in the Lancet for Nov., 1851.

MEARS (30) describes a small secondary growth of *epithelial cancer* removed from the meatus urinarius.

ANDANT AND LONSTALOT (31) detail a novel method of *extracting a foreign body from the male urethra.* A man suffering from stricture, passing an elastic catheter, No. 7, introduced the wrong end of it, that is the end to which was attached the bony rim. After reaching the perineal region he attempted to withdraw the catheter but the ring became detached and remained within the urethra. Pain and frequent desires to micturate came on, so that he desired to have it pushed back into the bladder by Drs. Andant

and Lonstalot. The bone ring from another No. 7 catheter was obtained, and an iron rod made with a screw end so as to fit the same. The rod thus provided was passed down to the site of the bone ring by the patient himself, as he had had long practice in introducing a catheter, and on reaching the ring the rod was twisted in the fingers so as to screw it into it; this was successfully done, and the rod and ring slowly withdrawn, to the satisfaction of both patient and surgeons.

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2. The rite of circumcision, why sometimes followed by disease.—L. H. Cohen, N. Y. Med. Jour., Feb., 1874.
3. Retention of urine from enlarged prostate; aspirator used 15 times.—S. F. Speir, N. Y. Med. Rec., Mar., 1874.
4. Spasmodic stricture of the urethra.—N. Y. Med. Rec., April 15, 1874.
5. Congenital curvature of the penis, hypospadias; operation.—R. F. Weir, N. Y. Med. Jour., March, 1874.
6. Urethrotomy, etc.—F. N. Otis, N. Y. Med. Jour., April, 1874.
7. External urethrotomy.—Güterbock, Arch. f. Klin. Chirurg., Jan., 1874.
8. The photo-endoscope.—Stein, Berlin. Klin. Wochens. 3, 1874.
9. Treatment of paraphimosis.—Bardinet, N. Y. Med. Jour., July 1, 1874.
10. The structural changes in gonorrhœal epididymitis.—Schepelern, Med. Chir., Rundschau, April, 1874.
11. Electro-therapeutics of the male genital organs.—A. D. Rockwell, N. Y. Med. Record, July 15, 1874.
12. Treatment of gonorrhœa.—Haberkorn, Berl. Klin. Wochens., No. 34, 1874.
13. Urethral strictures and their treatment.—Jassi, Arch. d. Med. Chir. è. Igiene, April, 1874.
14. A new method of circumcision by Howse.—Am. Practitioner, Oct., 1874.
15. Stricture of urethra and treatment by intra-urethral massage.—L'Union Médicale, No. 100, 1874.
15. The treatment of balano-posthitis and of phymosis symptomatic of simple chancre.—C. Mauriac, Le Progrès Méd., Sept. 19, 1874.
17. Slippery elm bougies.—Moncure, Virg. Med. Monthly, Oct., 1874.
18. Treatment of gonorrhœa by sulphate of zinc and acetate of lead.—Bedoin, Practitioner, Oct., 1874.
19. Treatment of gonorrhœa with tannin and glycerine paste.—Schuster, Vierteljahrs. f. Dermat. und Syph., Jan., 1874.
20. Bromide of potassium in the treatment of gonorrhœa.—Bligh, Practitioner, Feb., 1874.

## Reviews and Book Notices.

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### *Recent French Works upon Syphilis.\**

FOURNIER'S large volume is certainly the most important clinical treatise upon syphilis which has been published for many years past. It is composed of lectures delivered at the Lourcine Hospital, in Paris, which, being twenty-eight in number, form a book of about eleven hundred pages. As the task of the critic will consist, in the main, in unreserved praise, it is well to state, at the outset, that if the work has a fault at all, it is in its diffuseness of statement and in its somewhat unnecessary repetitions. Even with well-trained lecturers repetitions of statements will sometimes occur, but they should be remedied in the preparation for publication. In the present instance, perhaps, they are more pardonable than in others, as they do not arise from a desultory and unskillful handling of the subject, but, on the contrary, from a conscientious desire of the author to impress firmly points of importance. With this reservation, it may be said that the descriptions are clearly and forcibly given in a smooth and exceedingly pleasant style of diction. The plan of the work is somewhat peculiar in the fact that a number of cases are taken to illustrate each particular lesion until the whole subject is compassed. As developed in this work, this plan is valuable, as by it descriptions are fully brought out. It is almost needless to say that in order to teach in this manner, a large number of cases are necessary, and such are readily accessible in the wards under M. Fournier's care.

The supplementary title of the work informs us that the study is particularly upon the syphilis of women, and although much important knowledge is conveyed as to the disease in that sex, the descriptions in general apply with equal correctness to men.

\* Lectures upon syphilis (*Leçons sur la syphilis*). By A. Fournier. Paris: Delahaye, 1873.

Historical and practical treatise upon syphilis (*Traité historique et pratique de la syphilis*). By Dr. E. Lancereaux. Paris: G. Bailliére, 1873.

Theoretical and practical treatise on syphilis (*Traité théorique et pratique de la syphilis*). By Armand Després. Paris: G. Bailliére, 1873.

The origin of syphilis (*Origine de la syphilis*). By Edmond Bassereau. Paris: J. B. Bailliére, 1873.

A study of the hepatic lesions of syphils in the adult (*Etude sur les accidents hépatiques de la syphilis chez l'adulte*). By Dr. Lucien Lacombe. Paris: A. Delahaye, 1874.

Perhaps there is no treatise, certainly none since the publication of Ricord's *Leçons sur le Chancre*, which contains such a full and accurate history of the initial lesion as does this work. The six lectures devoted to this subject are remarkable for their force and clearness. The laws of the development of syphilis as laid down by the author are stated in a simple and methodical manner, and their perusal will materially assist in the study of the disease. Every phase and form of chancre are described in a clear manner, and the points of difference in diagnosis are forcibly drawn out. With the same completeness and accuracy, the glandular, mucous, and cutaneous lesions of syphilis are traced. The descriptions of the syphilides are excellent and cannot fail to assist greatly in clinical study. A characteristic and somewhat unique feature of the book is the description of the peculiar nervous phenomena which often occur in the early syphilis of women. This portion is particularly valuable, and develops points which have not heretofore received the attention they merit. The peculiarity of the author is well shown by this portion of the book. The effects of syphilis upon the organism generally are considered at some length, and the portion of the work in which it is shown how the functions of the viscera are perverted by secondary syphilis, and how the general nutrition of the body is lowered, is perhaps the most important of the whole. In his treatment of this part of the subject the author shows that he does not confine himself in his study to descriptions of external affections simply, but takes the broad view of general pathology as applied to the investigation of syphilis. In this volume, primary and secondary syphilis only are considered, and the tertiary form is left for a future time. A noticeable section of the book is that on the treatment of syphilis. This, perhaps, is one of the most lucid and convincing arguments in favor of a mercurial course of treatment to be found in any language, and its directions should be mastered by every one who treats syphilis. Taken as a whole the work is of great value. It shows, upon the part of the author, a keen power of observation, a clear perception of facts, and a very felicitous mode of expression.

The appearance, at the commencement of the year, of the second and enlarged edition of the classical work of LANCEREAUX upon syphilis was a welcome surprise to those who had become familiar with the first edition. This volume fills a void in literature very much felt, as it is in reality an encyclopædia of the disease. In looking over the various chapters one is struck with the great and extensive reading of the author, for under each head we find a very copious, and, in general, nearly perfect bibliography. The scope and general plan of the present work is similar to that of the first edition, the various subjects being treated of historically, clinically and pathologically. While every praise must be accorded to the author for

his labors in the field of history and pathology, and in giving the different views held by authors upon the various subjects, in a concise and accurate manner, it must be confessed that in the matter of clinical description there are other authors who excel him; indeed, the clinical part critically examined is, in this as in the first edition, the most unsatisfactory portion of the task. Still in the main the clinical descriptions will answer the purpose of suggesting points to the reader which his own experience and reading will elaborate and verify. The general arrangement is the same as in the former edition, the lesions of the various organs and tissues are studied one after the other, and the whole constitutes a very complete picture of the disease. In reading the work carefully one observes that the author has availed himself of nearly all of the late observations, consequently his work covers ground not touched by many other works. In this matter of giving the views of other observers we find a clearness and candor which is certainly commendable. The limits of this review prevent minute analysis of the work, and the fact of its having been so well known in its English translation, renders it unnecessary to say more than has already been said. The present volume is printed on better paper and with clearer type than its predecessor, and is on the whole a handsome as well as valuable book. The chromo-lithographs, representing various pathological conditions, are very beautifully executed, and are of importance.

In striking contrast with the pains-taking and matter-of-fact work of *Lancereaux* is the vague, theoretical and desultory volume of *DESPRES*. On looking at the title page of the work, one is prepared for any amount of theory, and the perusal of it certainly indulges him to satiety. Nearly one-third of the work is occupied with a dreary and unprecise history of syphilis and of the various views and doctrines held regarding it; then we come to a consideration of the nature of the disease by the author, who endeavors, certainly with very little skill and by far-fetched arguments, to prove that it is a form of purulent infection. At this stage one is about prepared to throw aside the work, but curiosity tempts him further. Then follow descriptions of various forms of syphilis, which are the elaboration, in the author's mind, of ill-digested facts and faultily observed cases, the whole leaving the reader in a maze of uncertainty. In the same manner the lesions and symptoms proper are treated of; making, perhaps, the most unsatisfactory description to be found in what is designed to be a systematic treatise. Indeed no one can possibly be taught by the book upon any point of clinical history or diagnosis. Another marked defect is the garbling of statements and opinions of other observers. Indeed, the author certainly seems unable to grasp the bearing of their views, and in using

them produces an unprecedented literary chaos. True to his errors, he still maintains his anti-mercurial views, and his chapter on treatment is a curiosity of literature. As an example of the absurd and far-fetched arguments to be found in the work, we could cite the following: It is known that sometimes hypodermic injections of corrosive sublimate cause inflammatory indurations of the connective tissue, which may even ulcerate. Now, Després distinctly says that these swellings are examples of the power of mercury in causing the development of gummy tumors, and that they are, indeed, veritable gummy tumors; hence this is a convincing example of this power which he claims mercury has of producing all tertiary lesions. This is the last bombshell in the camp of the mercurialists! Certainly, great must be the trepidation of the latter at the onslaught (the present may be taken as a fair sample) of such a doughty champion as Després. We have recently perused an equally illogical and inane production from another writer of the same faith namely, Hermann, of Berlin.

The name of BASSEREAU, upon a title page, will always attract attention, particularly if the work is upon syphilis, and even upon that hackneyed portion of it relating to its origin. Following in the footsteps of an illustrious sire, we find that the son of the man, who may be considered to be the founder of the doctrine of dualism, engaged in the study of that protean disease, syphilis. The present little volume is the inaugural thesis of the author, and we are informed that it is merely a part of his studies, the completion of which is to appear at a future time. So much has already been written about the origin of syphilis, that one can scarcely be tempted to peruse a new work on the subject. We must confess that the present brochure does not present any noticeable feature, but that it goes over the same dreary ground in an uninteresting and unsatisfactory manner. The author evidently accepts the American origin of the disease. There is a want of decision of statement in the book which is rather disappointing. Since this was written we have been pained to learn that young Bassereau, who is said to have evinced ability of an high order, has died after a short illness.

The monograph by LACOMBE is one of those compilations which while it contains nothing new, is useful in presenting a tolerably good view of the subject. The pathology of hepatic lesions is studied at some length; but beyond what has already been said about them by Virchow, Cornil and Ranzier, and Lancereaux, the author has very little to add. Their clinical history is traced somewhat unsatisfactorily; but the inherent difficulties of the subject must be taken into consideration in extenuation of the fault. In speaking of the jaundice, sometimes observed early in the secondary period, the author advances the opinion, after giving those already

entertained, that it depends upon gastro-intestinal catarrh. A criticism may be passed on this work which will apply to many others; that is, that the illustrative cases are reported in a too prolix manner and are burdened with details irrelevant to the subject.

R. W. TAYLOR, M. D.

*On the Modified Turkish and Vapor Bath, and its Value in Certain Diseases of the Skin.* J. L. MILTON: London.

The subject of the use of baths in cutaneous diseases has received far too little attention on this side of the water, and any contribution to its study we hail with much pleasure. Those who have visited St. Louis in Paris, and have followed Hebra in Vienna, know the great service rendered by this form of medication. The University College Hospital of London, has established a bathing department, and we are glad to learn that the new hospital of the University of Pennsylvania is likewise about to erect suitable apparatus for this under the learned and able guidance of our collaborator Dr. Duhring.

But Mr. Milton has, as it were, popularized the vapor bath, by giving in his little book a description of one which can be employed in the patient's house at a very small expenditure of labor and cost. It consists merely in a suitable lamp and boiler for generating a considerable amount of heat and steam, which is placed under a cane-bottomed chair (the chair should be made for the purpose when many baths are to be taken, as the steam loosens the glue of ordinary furniture), and a proper covering for the body to retain the heat and vapor. We cannot describe the lamp and boiler in full other than to say that the former is what is known as a Russian lamp, wherein spirits in an outer chamber are volatilized by the heat and produce a blast which is directed through the centre of the flaine, and the boiler has a number of tubes connected with its bottom outside, around which the flame plays, thus offering a large amount of heating surface. The covering is formed of what he calls "crinoline" with a flannel lining, which is held out from the body by a series of bamboo hoops large enough to have the whole cover the body from the neck down and the chair upon which the patient sits. We cannot explain what the author means by the *crinoline* outer covering, but presume that some such material as thick gutta-percha paper, or cheap oiled, rubber, or enameled cloth would answer the purpose. The head is left out, the affair being drawn together around the neck. Ten minutes is an average duration for a bath, and they may be taken two or three times a week; the bath should not be entered until steam begins to be generated in considerable quantity.

When more than the simple action of the vapor is required, the

body may be kneaded, soaped and lathered beneath the crinoline by the patient, and on throwing off the cover he may step into a cold bath, or take a shower, or even a sponge-off; a glass or two of cold water while in the vapor will assist its action.

Mr. Milton recommends the persistent use of this bath in any of the diseases where the skin is dry, and harsh, and scaly, as chronic dry eczema, psoriasis, ichthyosis, etc., so heartily that we cannot but hope that others will use it.

*Diseases of the Skin, in twenty-four lectures, by HENRY EVANS CAUTY: Liverpool. J. & A. Churchill, London, 1874.*

From the reputation of the house issuing this book, and from the advancing state of dermatology, we should expect that a large octavo work of nearly 400 pages would either contain some original matter, or present what is known on the subject in a clear and inviting manner. We regret to say that such is far from being the case in the work before us, for, with the exception, perhaps, of Mr. Meldon's "treatise," published in 1872, or that of Jabez Hogg on parasitic diseases, we do not know of any late publication "on diseases of the skin" which possesses less to claim attention either from the practitioner or the student. We speak plainly from necessity, for it is highly important that a branch of medicine already so obscure in the minds of some should not be further mystified by any more such books. It is unfortunate that so much good paper and beautiful typography should be thus wasted.

*Clinical Atlas of Skin Diseases. H. STANLEY GALE, M. B. London: H. Kimpton, 1874.*

We notice this only to denounce in the strongest terms the ignorance and temerity, if nothing worse, which would thus degrade ink, type and paper. Such works can be of no possible use to any one, not even the author.

*Hebra on Diseases of the Skin. Vol. III. NEW SYDENHAM SOCIETY; translated by Waren Tay, F. R. C. S., 1874.*

We have not space to review this book, which indeed has been already noticed last year in the original, and we will but welcome it to the English-speaking world and thank the translator for his faithful and able work. The greater part of the present volume is written by Dr. Moriz Kaposi, and embraces the cutaneous hypertrophies, atrophies and a portion of benign new-growths. There remain the articles on rhinoscleroma, lupus, leprosy and carcinoma, yet to be published, which, together with the remaining portion of Hebra's work which has not yet appeared in German, will form, we presume, one more volume, making four in all of the New Sydenham Society's translation.

## Correspondence and Miscellanies.

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### MEDICAL SPECIALTIES IN LONDON.

BY JAMES MORRIS, M. D.,

*Fellow of University College.*

TO the readers of the journal of a medical specialty, and particularly to those in the large and wealthy cities of the United States, whose conditions are in many respects so rapidly approximating to our own, a few remarks on the state of specialties in London, as yet the largest and wealthiest city in the world, can hardly fail to prove interesting.

By showing the comparative position of medical specialties, light will be thrown on the position of the cutaneous specialty. Here is a list of special institutions chiefly taken from the medical directory of last year. Omitting establishments for convalescents and for lunatics, of which few are urban, as well as those which have not one distinctive medical character, and one only, the list stands thus:

Accidents.....	1	Incurables.....	4
Cancer.....	1	Lying-in.....	8
Children.....	7	SKIN.....	6
Consumption & Chest.....	5	Small-pox.....	2
Cripples.....	3	Spinal.....	1
Ear.....	3	Stone.....	1
Epilepsy & Paralysis.....	2	Teeth.....	2
Eye.....	5	Throat.....	1
Fever.....	3	Vaccine.....	2
Fistula.....	2	Venereal.....	1
Hernia (Trusses).....	2	Women.....	5
Hip.....	1		

We have here sixty-eight special institutions, and the list is not quite complete to the present time. Some great specialties as ovariotomy and lithotritry are not included, not having local habitations.

Our nine largest medical schools have all recognized the ophthalmic, the dental, and the forensic specialty; and generally, with more or less distinctness, the venereal diseases and those of women and children; four recognize mental diseases and three hygiene or public health. Besides those just mentioned, six recognize the skin as a special department; four have specialized aural

diseases; three have singled out diseases of the throat, and one cancer. From the foregoing, it will be seen that the cutaneous specialty, as it is a natural specialty, is also one very firmly established here. It has already a broad literature of monographs, atlases, published photographs and models, as well as periodicals in English, German, French and other languages. But a still more elaborate cultivation of so wide a territory cannot fail to yield much grain to the great storehouse of medical knowledge, if it be worked in the spirit of the motto *Non sibi, sed toti.*

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At the last meeting of the New York Dermatological Society, it was resolved to place the library of the Society at the service of the medical profession, in connection with one of the larger public medical libraries in this city. Donations to the library are earnestly solicited from authors of books, monographs and journal articles, and may be sent directly to the library committee, care of G. P. Putnam's Sons, 308 Fourth avenue, New York.

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Authors of papers, theses, etc., will assist in the preparation of reviews and summaries by our collaborators, by forwarding separate copies of their works to the "ARCHIVES OF DERMATOLOGY."

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The Editor regrets that press of matter has again crowded out several original articles, many reviews of recent works on dermatology and syphilis, and a copious bibliography. Reports may be expected in the next issue from the collaborators who contributed to the October number.

"Brevity, indeed, upon some occasions, is a real excellence."

— CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

APRIL, 1875.

## Original Communications.

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### PELIOSIS RHEUMATICA.\*

(PURPURA RHEUMATICA.)

BY F. P. KINNICUTT, M. D., NEW YORK.

THE coincidence of certain erythema, *e. g.* erythema papulatum, tuberosum and nodosum, with rheumatismal affections, had long excited the attention of observers, when in 1829, Prof. Schönlein, under the title of Peliosis Rheumatica, described a purpuric form of eruption occurring with rheumatismal symptoms, *i. e.* acute articular pains; he regarded the characteristics of the affection to be sufficiently marked to entitle it to the position of a new and independent disease. Later we find mention of peliosis rheumatica by Fuchs, Hebra, B. Arnold, Wunderlich, Neumann and other German observers. Hebra's clinical description of the disease coincides very nearly with Schönlein's, and its conciseness tempts me to quote it entire.†

"Dragging pains, accompanied by feverish symptoms, begin to be felt in the joints, most often in the knees and ankles, without any obvious pathological change in these parts. In a few days there appear in the neighborhood of the painful joints, or scattered more widely over the body, especially on the abdomen

\* Read before the New York Dermatological Society, June 9, 1874. For discussion thereon, see page 233.

† Hebra on Diseases of the Skin, vol. II, p. 422, Syd. Soc. Transl.

and breast, dark red, livid or almost black spots, which remain quite unaltered under pressure of the fingers; as soon as they appear, the rheumatic pains usually subside. These spots are formed by extravasations of blood, and are surrounded by a slight circle of active congestion for a short time after their first appearance. They are round and vary in size from a hemp seed to a lentil; occasionally they rise somewhat above the level of the skin, but as a rule are perfectly flat. After a day has passed they become darker, then reddish brown and at last pass into yellow and disappear, without any desquamation, after lasting altogether eight or ten days. During the period of involution fresh pains sometimes occur, and with them follows a new eruption of petechiæ, so that the whole illness may be prolonged for weeks. This form of purpura is usually met with in the strong and healthy. It is most frequent between the ages of twenty and thirty, has never been seen in children or aged persons, and is more common among men than women."

Hebra's statement as regards the non-occurrence of the disease in children and the aged, and the absence of any sign of pathological change in the affected joints, is not borne out by the experience of other observers.\* A number of cases are recorded of its occurring in childhood, and the age of one of the patients, whose history will be given further on, who was under my observation throughout her illness, is only eleven. The presence of apparent pathological changes in the affected joints, is moreover, mentioned by many authorities, and in a case † described by Leuthold ("aus der Traubeschen Klinik") such changes were actually found at the post-mortem examination.

Fuchs ‡ places Peliosis Rheumatica among his 'Rheumatoses,' and Schönlein, Hebra, B. Arnold and Neumann, apparently believe in the existence of a relationship between this affection and rheumatism. Wunderlich regards the articular pains as

\* In the article on Peliosis Rheumatica in the revised edition of Hebra's work, published since the writing of the above, the sentence "it has never been seen in children and the aged" is omitted. Lehrbuch der Hautkrankheiten von Hebra und Kaposi, 1874, p. 709.

† Berl. klin. Wochenschr., 1865, No. 50.

‡ Die Krankheiten der Haut, 1840.

merely an epiphomenon, thus forming out of it a variety of Purpura. The position accorded by the majority of the German observers to peliosis rheumatica, that of a well-defined affection, is not generally admitted by the French school. In a monograph by M.M. Legrand and Duriau\* the subject is reviewed at length and two cases of Purpura Rheumatica are cited; an analysis of them, they claim, shows an identity as regards the probable etiology, and symptomatology of this affection with the *Érythème noueux* of the French, the *Erythema nodosum* of the English. The peculiarities of the eruption of Peliosis Rheumatica, as described by the Germans, are regarded by them as hardly sufficient to constitute even a variety of the *Érythème noueux*; in other words, they make the two affections absolutely identical. Later we will again refer to their conclusions. Bazin † accepts the views of M.M. Legrand and Duriau. Trouseau ‡ apparently regards Purpura rheumatica and Erythema nodosum as identical, as in describing the latter affection he mentions that Professor Schönlein has given to it the name of Peliosis rheumatica. As he makes no other mention of the latter affection than that embraced in these few words, it is possible that he may have been unfamiliar with the disease as described by Schönlein and other German authors. In an exhaustive monograph by Numa Bès § on *Érythème noueux*, this author says, "We must accept with the greatest reserve the opinion as to the identity of the two affections." By the English dermatologists, we find scant mention of purpura rheumatica as such. Tilbury Fox || speaks of the description of a special phase of Purpura, under the title of peliosis rheumatica, by the continental dermatologists, but asserts that it is really only erythema complicated by haemorrhage, the duration and course of which are those of erythema papulatum. Wilson\*\* under the head of

\* *De la Peliose Rheumatismale ou Érythème noueux rheumatismal.* Frederic Duriau et Maximin Legrand, Paris, 1858.

† *Affections Génériques de la Peau*, Vol. I, 1862, p. 68.

‡ *Clinical Medicine*, Vol. II, p. 243.

§ *De L'Érythème noueux dans certaines Maladies*, Paris, 1872.

|| *Skin Diseases, etc.*, London, 1873, p. 393.

\*\* *Diseases of the Skin*, London, 1873, p. 350.

purpura simplex, describes a case which, it seems to me, must rather be regarded as one of purpura rheumatica, and as such will be cited further on.

In our own literature, we find mention of the affection under discussion, in articles by Drs. Duhring\* and Hardaway.†

With this presentation of the views of the Continental and English observers in regard to the nosology of Purpura Rheumatica, we will now pass to the histories of three cases of this affection. They illustrate very clearly the many interesting points in this disease, and will pave the way for an impartial discussion of the vexed question as to its true position among diseases.

*Case 1.*—Prof. Traube's‡ case: “A cabinet-maker, 39 years old, with left Pyo-pneumo thorax *e causa tuberculosa*, constant accelerated respiration and fever, had over-taxed himself by taking care of another patient, and complained afterward of unusual weakness, with dragging pains in the forearms and legs, with sensitiveness in the joints. He succumbed more and more, had painful diarrhoea and œdema of the feet. There soon appeared on the dorsum of both feet, small, dark red spots, from the size of a pin's head to that of a lentil, which neither projected above the surface of the skin nor disappeared under pressure of the finger; similar larger spots appeared upon the ankles, which were intensely painful to the touch; the diarrhoea continued obstinately. With a decided swelling of the right knee-joint, there appeared a few days later a further eruption of petechiæ, which, although more numerous on the lower extremities and forearms, were still to be found on other parts, with the exception of the thorax and face; there was severe accompanying œdema of the hands and swelling of the finger-joints.

Later there appeared, instead of the ecchymoses, here and there, blood vesicles. This whole affection lasted, with a partly continued and partly remitting fever, about a fortnight. The patient died at the end of three weeks. In a number of joints, which during life were painful and tender, was found a more or

\* Philadelphia Medical Times, May, 1874.

† Missouri Clinical Record, May, 1874.

‡ Berlin Klin. Wochenschrift, 1865, No. 50.

less abundant, colorless, viscid, synovial fluid; the synovial membrane was in part pale and oedematous, in places injected, with here and there partly fresh, partly pale brownish extravasations,"

*Case 2.*—Dr. Wilson's case may be briefly stated, as follows: A merchant, aged 42, suffering in health from too close an application to the duties of the counting-house, subject to frequent attacks of dyspepsia, constipation and rheumatism, after two or three weeks of dyspepsia, was suddenly seized during the night with rheumatic pains across the chest and back, most severe in the axilla; he also had pains in one of his hips. This attack was accompanied with rigors; the bowels were constipated, urine scanty and high-colored, with red deposit; the appetite was not affected. After ten days of suffering, a crop of petechial spots made their appearance upon his legs and arms, immediately following the action of a blue pill; after four days, during which fresh petechiæ continued to appear, a crop of vibices suddenly broke out upon the lower limbs; the vibices became the seat of bullæ, which were filled with a purplish fluid; the integument was oedematous. These symptoms continued for six or seven weeks, when the petechiæ and vibices gradually faded, the skin got well, and he seemed to be recovering. Six weeks later a similar eruption appeared, following similar prodromal symptoms. The duration of the second attack corresponded with that of the first. The joints were swollen and tender during these attacks, and the patient himself stated that he could always foretell an eruption of petechiæ by an increase of pain in the joints.

*Case 3.*—On February 16, 1874, Hannah O., aged 13, first came under my observation. Her mother died of acute articular rheumatism; father is still living, but phthisical. She has always been a delicate child; several years ago she had typhoid fever, but with this exception there is no history of any serious illness until last autumn, when she was confined to bed for several weeks with remittent fever; has not been strong since. She gives no direct evidence of any rheumatic trouble in the past. Five weeks previous to date mentioned the patient was seized quite suddenly with chilly feelings, feverish symptoms, headache, pains in knees, ankles, elbows and wrists; the pains in these situations increased rapidly in intensity, and by evening of the day on which the symptoms first appeared all movement was rendered impossible; the pains were described as of exceedingly acute character, and greatly increased by pressure; no swelling or redness about

articulations was observed. With the increase in articular pains an abundant eruption of dark red spots appeared about knees and ankles, along legs (principally the anterior surface), also in a slighter degree about elbows, wrists and on forearms. On the following morning the pains were less acute; during the day they gradually disappeared; and by evening the patient complained only of a little stiffness in the joints; she says that there was no increase in the eruption. She felt very well during the rest of the week, and the eruption gradually faded, leaving only yellowish "stains." On the seventh day from the above described attack, after exactly similar prodromal symptoms, a similar eruption appeared, confined, however, to the knees, ankles and legs; the articular pains were acute for twenty-four hours and then disappeared. Felt well during rest of week. On each succeeding seventh day since (the family who are very intelligent, say that they are positive in regard to the correctness of this statement) the patient has suffered from an attack in every respect, similar.

When first seen February 16 (last attack on 14th), the patient presented marked cachectic appearance; countenance pallid. On examination of the heart, a loud systolic murmur was detected, heard with greatest intensity at the apex; it could easily be traced beyond, and was distinctly heard at angle of scapula; slight increase in transverse cardiac dullness, superficial and deep; abundant eruption of dark red spots about the knees, ankles, the entire length of the legs, principally on anterior and outer surface; similar but less abundant eruption about elbows, wrists and along inner surface of forearms. On passing the finger over the spots, none are found to project above the surface of the skin; they are perfectly flat, do not disappear upon pressure, are not confined in their situation to the base of the hairs, and vary in size from that of the head of a pin to a quarter of an inch in diameter. Scattered over the same parts are to be seen numerous yellowish spots or stains, traces apparently, of former eruptions. No heat, swelling or redness about the articulations; no pains at present, acute two days ago; feels very well, appetite fair, sleeps well, bowels regular, no fever. Ordered sulphate of quinine, gr. x. daily, cod-liver oil and iron.

February 18.—Patient has felt very well since last note. The appearance of the eruption has changed in a marked manner; reddish-brown, violet and yellowish spots are visible in place of the former eruption.

*February 22.*—Yesterday, seven days from last attack, a similar one occurred; some stiffness of joints to-day; yesterday acute pains, increased on pressure, with no swelling or redness, however; abundant eruption, similar in all respects to former ones, about knees, ankles and legs (anterior and outer surface.)

*February 29.*—Has felt well, with no fresh eruption since last note, until yesterday, when she had another attack; abundant fresh eruption on lower extremities; articular symptoms the same as in previous attacks. Ordered to continue the quinine, with directions to take whole amount in one dose on morning of 7th.

*March 8.*—Severe attack yesterday; eruption more abundant than ever before, confined, however, as has been the case of late, to the knees, ankles and legs; articular pains severe; only stiffness of joints complained of to-day. Chemical and microscopic examination of the urine gives negative results. General condition of patient has been constantly improving since she has been under treatment. Ordered; quinine to be discontinued; to take two drops of Fowler's solution three times daily; iron and cod liver oil continued.

*March 14.*—No attack; patient feels perfectly well.

*April 6.*—No further attacks; patient is in excellent condition.

It should be mentioned that during the attacks the eruption became more abundant when the vertical position was assumed, with an increase also in the intensity of the articular pains. Throughout the affection there was never any eruption to be detected upon the mucous membranes, nor evidence of any hemorrhage into the mucous cavities. The patient has been under careful observation up to present date; there has been no recurrence of the trouble, and her general condition has continued excellent. The cardiac murmur remains.

A study of the above cases reveals to us the identity of the eruption in them all, at the same time convincing us as to its true character. We find no evidence of an inflammatory process, of hemorrhagic, or serous exudation into the sub-cutaneous connective tissue; on the contrary, we discover an eruption indisputably due to superficial cutaneous hemorrhages. Again, we find the existence of acute articular pains in all, preceding and accompanying the eruption; pains increased on pressure and movement, accompanied in two of the three cases by obvious patho-

logical changes in the affected joints, the morbid condition in Prof. Traube's case being confirmed at the autopsy. In Case II a rheumatic diathesis is shown to exist, and in Case III it would seem justifiable to suppose the existence of an unrecognized rheumatismal affection at some previous state. Finally, a marked tendency to recurrence is exhibited. The periodical recurrence of the symptoms in Case III may be explained by the well recognized fact of the periodic character which may be impressed upon disease by malarial influence.

We are now in position to consider the justness of the views held by the German school, in regard to the true place which should be assigned to *purpura rheumatica* among diseases. The question which first presents itself to us, is the possibility of a real differentiation of this affection from the diseases with which it has been asserted to be identical—*i. e.*, from purpura in the common acceptation of the term on the one hand and from erythema nodosum on the other. The eruption of purpura simplex closely resembles that of the peliosis rheumatica as regards its color, dimensions, its preferred seat, its tendency to recurrence; yet in the one we find prominent articular symptoms, in the other an absence of them; for the soreness and tenderness of the affected parts, the muscular pains which are always present in greater or less degree in purpura simplex, can in no way be confounded with the acute pains, attacking by preference the large joints and as a rule confined to these situations, in the purpura rheumatica. May we not regard this symptom of the latter affection sufficiently characteristic to distinguish it from what is ordinarily known as purpura simplex?

The severe constitutional disturbance, the large ecchymoses, their extension to mucous membranes, the occurrence of hæmorrhages into the mucous cavities in purpura hæmorrhagica, are never observed in the disease under discussion. Let us now pass to the consideration of the question, as to the asserted identity of peliosis rheumatica with erythema nodosum. Bearing carefully in mind the character of the eruption in the former affection, as

described by Schönlein, Hebra and other German observers, moreover as exhibited in the cases whose histories have been presented, let us compare it with the cutaneous manifestation in the latter disease, as recognized by the three great schools. By Hebra,\* quoting his own words, "the term erythema nodosum is applied to "an affection consisting of tumors of a pale red color, raised above the level of the skin, semi-circular or oval in form, tender on pressure, varying in size from that of a pea to that of a man's fist; at first of a pale red color, they afterward become dark red and then livid; the color gradually fading, a yellowish coloration remains for a variable length of time." The eruption is thus described by Bazin † "red spots more or less regularly oval, and of which the longest diameter, parallel to the axis of the limb, varies from some millimetres to four or five centimetres, projecting at their centre to about the size of a pea, a hazel nut or a small walnut, and which gives to the finger in passing from the well to the affected parts the sensation of a real nodosity, inclosed in the sub-cutaneous cellular tissue; the coloration of the affected parts passes successively from red to dark red, and soon gives place to a blue and greenish ecchymotic tint, indicative of an extravasation of blood into the sub-cutaneous connective tissue. Finally, an obscure fluctuation is often felt in these tumors, but suppuration or ulceration is never observed." Dr. Wilson's description coincides with Hebra's and Bazin's, and it is to an erythematous dermatosis, presenting like characteristics, that the term erythema nodosum has been applied by our own observers. Are we not therefore justified in concluding that the only points of resemblance between the eruption of this affection and that of purpura rheumatica, consist in an extravasation of blood, occurring, as we know, in various dermatoses, and a certain tendency to recurrence. In the one case, we have to do with a true inflammation, accompanied by an extravasation of serum and blood into the sub-cutaneous connective tissue; in the other, with

\* Hebra on Diseases of the Skin, Vol. I, p. 289, Syd. Soc. Trans.

† Affections Génériques de la Peau, Vol. I, 1862, p. 69.

a simple cutaneous hæmorrhage, unattended by any apparent inflammatory action.

In the case of peliosis rheumatica cited by M. M. Legrand and Duriau,\* from which their argument as regards the lesional identity of the two affections is chiefly drawn, the eruption is thus described: "There is felt, under the pressure of the finger, a nodosity corresponding to the whole extent of the spot; certain nodosities are united by a yellowish track, often scarcely visible, but very perceptible to the finger as a small cord rolling under the skin." We can only say that this form of eruption does *not* correspond with that described by other observers as characteristic of peliosis rheumatica, or as exhibited in the cases whose histories we have given. Aside from the cutaneous manifestations, do we find evidence of identity? M. M. Legrand and Duriau necessarily admitting the *constant* presence of rheumatic symptoms, *i. e.* acute articular pains, in purpura rheumatica, in order to establish their argument of identity, are obliged to maintain the existence of a similar constant characteristic in erythema nodosum. Many distinguished authorities are quoted by them in support of this point, but equally distinguished names are to be found in the ranks of the opposition. Wilson and Fox recognize the *co-existence* of rheumatic symptoms *only in a certain number* of cases. To Hebra, Neuman and other German observers *this co-existence does not exist*. Articular complications are hardly mentioned by Willan or Bateman. Finally, the experience of our own observers is to the effect that such symptoms are by no means constant in cases of erythema nodosum.

It is thus evident that we have distinguished authority for insisting upon the *absence* of articular symptoms in many cases of erythema nodosum. This is an important point in favor of the non-identity of the two affections, as such symptoms are *pathognomonic* of peliosis rheumatica, as recognized by the Germans.

Other asserted points of resemblance between erythema nodosum and purpura rheumatica, as, a similarity in the invasion

\* Op. cit. p. 5.

of each, in the seat and spread of the eruption, in the general course of the affections, can have little weight in support of the argument of identity, when we recall the fact that many diseases essentially different in their nature, nevertheless present certain general common characteristics. We may formulate the conclusions which, it seems to me, we are justified in deducing from the above consideration of the subject, as follows:

1. That the following group of symptoms, first described by Prof. Schönlein under the title of peliosis rheumatica, is occasionally found associated in the same individual, namely: An eruption of dark red spots, due wholly to superficial cutaneous haemorrhages, accompanying or following rheumatic symptoms, *i. e.* acute pains attacking nearly simultaneously several of the joints, generally the larger ones, with or without obvious pathological changes in these parts; a marked tendency to recurrence of all the symptoms, whereby the disease may be prolonged for many weeks, the disturbance of the general economy, in the uncomplicated affection, being comparatively insignificant.
2. That this group of symptoms is sufficiently characteristic to permit of a differentiation of this affection from the diseases with which it has been asserted to be identical, from the different forms of purpura on the one hand, from erythema nodosum on the other.
3. That we are thus compelled to accord to it the position of a well-defined and independent affection.

A brief reference to the subject of the etiology of peliosis rheumatica must suffice. In Germany, Schönlein's opinion has remained the prevailing one, as to the rheumatismal nature of the affection. Its symptomatology, its frequent association with a known rheumatic diathesis, finally, the pathological changes actually found in Professor Traube's case, changes similar to those occurring in acute and gonorrhœal rheumatism, combine to support this view.

In conclusion, an outline of the ingenious theory advanced by Dr. Bohn, of Königsberg\* in regard to the pathology of

\* Jahrbuch für Kinderheilkunde, 1868, pp. 394-395, 401-402.

purpura rheumatica, will prove interesting. Starting with the proposition that this affection and erythema nodosum are identical, his opinion being based upon certain general resemblances between the diseases, he would explain the cutaneous lesion by the supposition of a temporary embolic plugging of the capillaries of the skin; a collateral hyperæmia being thus established in the immediate vicinity, hæmorrhages and hæmorrhagic inflammations arise. He seeks for the origin of the emboli in a spontaneous coagulation of the blood occurring during the fever (!) which introduces and accompanies the affection. The apparent influence exerted upon the cutaneous phenomena by the movements of the body, he suggests is due to the necessity of muscular contraction for producing the mechanical embolic plugging of the vessels. The effusion into the synovial sacs, he regards as due to similar causes, viz.: embolic plugging of a certain number of the capillaries of the synovial membrane, hence collateral hyperæmia, giving rise to both extravasations and an increased outpouring of the synovial fluid.

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## ON SPASMODIC URETHRAL STRICTURE.\*

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THE term spasmodic stricture is generally accepted as applicable to temporary muscular contractions of the urethral canal, arising from various causes. Before the muscularity of the urethra was demonstrated by Hancock and Kölliker, the presence of an organic muscular layer, surrounding the urethra, was inferred by such acute observers as John Hunter, Everard Home, Lisfranc, Dupuytren, Guthrie and others, from the fact, that obstructions to the passage of instruments, were met at all points in the course of the urethral canal, which were of a transient character, and that a distinct grasping of urethral instruments, was occasionally

\* Read before the New York Dermatological Society, February 9th, 1875. (Discussion reserved till next issue.—ED.)

recognized during their passage. Interference with micturition was, however, referred more particularly to spasm of the inorganic or voluntary muscles (*compressores urethræ*) which surround the urethra, in the membranous portion of the canal, and was attributed to the influence of reflex irritations, from various sources. The lines which naturally separate these two varieties of spasmodic urethral stricture have not usually been made prominent in considering the subject, although the distinct character of each, in regard to effect and locality, would seem to render it a matter of considerable practical importance. In regard to *cause*, we have the division of Sir Henry Thompson,\* into those which result from some local lesion, which he terms *eccentric* spasmodic contractions, and those in which this is not present or appreciable, and which may be supposed to have a *centric* origin. "Among the *eccentric* causes," he remarks, "none is so common as a partial organic contraction, \* \* \* acting especially in concert with such lesions, is the passage of urine over denuded and sensitive surfaces, which becomes a still more fruitful cause, if its character be altered from those of health in any way. All irritations, of whatever nature, within the urethra or in contiguous parts (such as haemorrhoids or ascarides in the rectum), would be included under the head of *eccentric* causes; while the term *centric* is made to include mental impressions, and all such as cannot be referred to a definite locality." "The grand distinguishing feature," says Sir Henry, "which marks the phenomena (of spasmodic strictures), and by which they are contrasted with organic strictures, is their *transitory character*.

Again, p. 49, Op. cit., he says: "Examples of pure spasmodic stricture are, without doubt, rare. Still, the influence of muscular action upon the urethra being considerable, it is important to recognize it in diseased conditions of the organ, since it commonly supervenes upon and complicates most of them. Indeed, neither organic nor inflammatory narrowing of the urethra, can well be imagined to occur without the co-existence, at some time

\* Thompson on Stricture of the Urethra, London Ed., 1858, p. 130.

or another, of spasmodic action, to some extent, in the muscular tissues around."

The views of Sir Henry Thompson, as above given (in 1858), would seem to have undergone some modification, since, in his latest work (*Thompson on the Urinary Organs*, London, 1869), while admitting urethral spasm as a physiological fact, he inclines to ignore it as a matter of importance to the competent surgeon. Thus, page 38, *Op. cit.*, he says of spasmodic stricture, "*it is an exceedingly useful excuse for incompetence. Spasm may prevent the urine from going outward, but I do not know that it ever prevents an instrument from going in.*" Mr. Erichsen, who is also deservedly eminent as a surgical authority, says: \* "From the fact that a patient will, at one time, pass his urine with the most perfect freedom, whilst if it be rendered acrid by drinking spirits, etc., almost complete obstruction will ensue, this tends to prove the existence of occasional spasmodic contraction of the canal." In referring to the views of Sir Henry Thompson, he says: "While I would not go so far as that surgeon in declaring that the name (spasmodic stricture) is merely a cloak for want of skill, I confess that I meet with spasmodic strictures less often than when I entered practice, and I believe the same to be the experience of others."

Dittel† says: "Spasmodic strictures are not generally accepted, and yet it cannot be disputed that difficulties which simulate stricture occur in certain morbid conditions and predispositions; *they lack only the constancy.*" Difficult micturition, strangury, and an alteration in the stream, were noted by him as resulting from venereal excess, from the acid urine of patients suffering from pyelitis, and from the urine of diabetic and arthritic patients, and from irritations of the rectum also and colon, by worms, excoriations and fissures, and also from mental anxiety. He cites an interesting case, where retention of urine resulted, apparently, from the latter cause alone, and which, on two occasions, he

\* Erichsen's *Science and Art of Surgery*, London, 1869, p. 1,114.

† Pitha & Billroth's *Handbuch der allgemeinen und speziellen Chirurgie*. *Dritter Band*, p. 49, 1872.

relieved by the introduction of a 25 Charriere catheter, after pressure against the anterior face of the obstruction (which was at the membranous urethra) for a quarter of an hour. Dr. Bumstead, in his excellent text-book (*Venereal Diseases*, Phila., 1870, p. 237), accepts the frequent occurrence of spasmodic urethral stricture, and says of it: "A spasmodic stricture is characterized by its *short duration*. It appears suddenly in persons of delicate habit, \* \* \* and as suddenly disappears. Exploration of the canal by means of a sound, after the spasm has passed, and frequently during its continuance, shows that there is no organic obstruction." In the recent work of Drs. Van Buren and Keyes (*Genito-Urinary Diseases with Syphilis*, New York, 1874, p. 93), accepting it as frequently resulting from above-mentioned causes, and as liable to occur in the attempted introduction of an instrument through the urethra, they remark: "It (the instrument) may be firmly grasped and held at any part of the canal, but this is more liable to occur just as the instrument is entering the *membranous* urethra, when its point may be detained for many minutes by the involuntary contraction of the *cut-off* muscles (*compressores urethræ*). If the end of the sound is held quietly for a few moments against the contracting muscle, the spasm will yield and the instrument pass on into the bladder."

In comparing the views of these recent, accepted authorities in regard to spasmodic urethral stricture, it will be observed that all agree as to its frequency, its transient character, and its easy management.

Dittel met with a case where the pressure of the end of a catheter for fifteen minutes, against the face of a spasmodic stricture, at the membranous portion, was required before it yielded. Van Buren and Keyes have evidently had similar experiences, as they note this occasional *persistence* of the spasmodic barrier. Sir Henry Thompson inclines to ignore the existence of the spasmodic stricture, and attributes to ignorance and incapacity the arrest of an instrument in its passage into the bladder, from any

cause but an organic one. In this Mr. Erichsen seems quite inclined to agree, although appreciating the possible occurrence of a spasmotic stricture which should be so persistent that it *might* be mistaken for an organic contraction.

It is not my purpose at this time to discuss the general question of spasmotic stricture. The recent investigations of Stilling (coinciding with those of Kölliker) would seem to show conclusively, that the muscular capacity of the urethral surroundings are quite sufficient to account for any amount of contraction which might be observed at any point. In his own strong language (supported by several admirable illustrations of the anatomy of the corpus spongiosum urethræ) he says:—" *the corpus spongiosum is a muscle through which the urethra runs.*" Dr. Stilling so demonstrates the muscular structure of this body, that it is at once seen to be an easy matter for such a contraction of the muscular structure of the corpus spongiosum to bring a strong contracting force to bear upon any part of the urethral canal. While thus accepting and claiming the liability of the entire urethra to spasmotic closure, which, under certain reflex influences, might embarrass, if it did not deceive, a well informed surgeon, I desire to present a series of clinical observations, to illustrate the probable frequent occurrence of spasmotic strictures at the membranous portion of the canal, which present *all* the diagnostic symptoms of true organic stricture, and which cannot, with certainty, be differentiated from organic stricture by any of the plans recommended by authorities.

*Case 1.*—J. W., frontiersman, aged 45, presented November, 1874, with a history of first gonorrhœa 20 years previously, and several subsequent attacks. Five years ago began to have difficulty in passing his urine; stream grew gradually smaller, until, after a debauch, he had complete retention, and was obliged to seek relief at a neighboring military post. After 36 hours suffering, he was relieved by the passage of a very small, flexible catheter, in the hands of the post surgeon. After this he submitted to treatment, by gradual dilatation, for several months. He then learned to pass No. 12 English soft bougie. From neglect, he has had some half a

\* B. Stilling, Die rationelle Behandlung der Harnrohren Stricturen. Erste Abtheilung, p. 9.

dozen attacks of retention during the past year. At last only the smallest instrument could be passed by the military surgeon, and he was advised to go East and have a radical operation performed, as there were no instruments at the post suitable to operate upon so small a stricture. His habit for a long time has been to pass his water very frequently during the day, in a very fine, irregular stream, and several times during the night. Examination—Is of large stature, looking like a strong man, who had endured much exposure and hardship. Made his water in my presence, in fine, short jets, chiefly dribbling. Circumference of the penis, three and one-half inches; size of meatus, 23 f. No. 23 f. steel sound passed easily through a very sensitive urethra to the bulbo-membranous junction, where it was arrested. Gradually decreasing bougies were introduced, until, finally, No. 12 f. passed into the bladder, closely hugged in the deep urethra. Allowing it to remain for a few moments, I found it free. I then withdrew it, divided the contracted meatus and stricture, extending for nearly half an inch back, and passed 34 f. solid steel sound slowly down to the bulbo-membranous junction, when it *slipped by its own weight into the bladder*. After the withdrawal of the sound the patient passed his water in a full large stream. From this moment he had no further trouble in urination, passing his water at intervals of six to eight hours during the day, and not at all at night, for the week subsequent to the operation, when he left for his home in the far West, apparently well in every respect.

*Case 2.*—Mr. W., aged 27, had first gonorrhœa four years previous, lasting in acute form for one month, and with painless discharge for six months longer. Has had frequent returns of the discharge without fresh exposure; had been under treatment for close, deep stricture for the past year, by several surgeons. Passed his urine in a small irregular stream, once in two or three hours. His last surgical attendant, after two months' treatment, by injections and internal remedies, sent him to me, not being able at any time to pass an instrument into the bladder. Examination showed external organs large, meatus contracted to 24 f., red and pouting, and bathed in a profuse muco-purulent discharge. Twenty-four f. sound is arrested at five inches. Only fine filiform will pass, and that is closely hugged. Three days after, pass filiform with ease and follow with No. 10 f.; then, with some effort, with No. 16 f. After this the filiform was again snugly held in the membranous urethra. I divided the stricture at the meatus freely, and introduced No. 30 f. steel sound, which passed, literally by its own weight, through into the bladder.

*Case 3.*—W. F., aged 45, had gonorrhœa 25 years ago. After five years, having much trouble in passing his water, he consulted a dis-

tinguished surgeon, and was informed that he had a deep organic stricture. Only a very small instrument would pass. By gradual dilatation, carried up to 14 English, the difficulty of micturition was then relieved, but would promptly return on the discontinuance of its regular use. Had a slight urethral discharge, following connection, but usually disappearing without any other treatment than the introduction of the sound. This introduction was continued with great regularity for a period of 20 years, on an average of once a month. Finally, having some misunderstanding with his surgeon, he took his sound and went to another, to whom he recounted his experience, and requested him to pass the instrument. Meeting with some difficulty near the neck of the bladder, his new attendant took a smaller instrument, then another still smaller; and finally, after causing much irritation and some haemorrhage, he was requested to desist. On the day following he came to my office. Examination showed a penis four and one-half inches in circumference, and an ample meatus. Thirty-four f. solid steel sound (22 English, introduced by my assistant, Dr. Fox), entered easily and passed, without the least force or halting, through the urethra and into the bladder. The size of the penis being four and one-half inches in circumference, indicated an urethral calibre of at least 40 of the French scale, or 28 of the English. I then introduced my urethra-meter, closed, to the bulbo-membranous junction, turned it up to 40, and drew it easily forward to within once inch of the meatus, where it was arrested, and required to be turned down to 34 before it would pass the obstruction. This showed a constriction at this point, of the value of six millimetres. As the patient objected to any cutting operation, the stricture was gradually dilated to 40 f., when the discharge ceased, together with all difficulty of urination, and after a month the patient passed from my observation.

*Case 4.*—Mr. F., age 32, gonorrhœa six years previous. After three years, had frequent and increasing difficulty in urination, which, after an excess, culminated in an attack of retention, which, after lasting 24 hours, was relieved with a small catheter. Had subsequently two or three attacks of same kind, relieved in same way. October 18, 1874, another surgeon, after repeated attempts, failed to pass the catheter. I saw him on the afternoon of the 20th. He had passed, *guttatim*, perhaps a pint of urine in the previous 48 hours. Bladder three inches above pubes; patient suffering and anxious; slight fever; pulse 90; temperature 101°. I put him at once under the influence of ether. Penis three and one-fourth inches in circumference (indicating urethral calibre 32 f.), meatus 23 f. Passed 23 f. solid steel sound without difficulty to bulbo-membranous junction, where it was arrested. Trying patiently one instrument after another, in decreasing sizes, I at last introduced a small filiform

bougie (No. 8 f. — 1 English), which was closely grasped as it passed through the membranous portion of the canal. The patient was apparently under the full influence of the ether at this time, but the spasmodic action of the compressores urethrae was distinctly recognized. The filiform was hugged at one instant and loose the next. I withdrew it and introduced a No. 10 f. This went in without difficulty. I concluded to pass down the staff of Voillemier and rupture, but found the screw on the bougie imperfect. I withdrew it and attempted to replace it by another. This was resisted in its passage, and it was only after a patient, prolonged effort that I finally succeeded. I then followed it with the staff, which was closely embraced in the membranous portion. I then cut the meatus freely, which I should have done before. In very carefully passing down the shaft No. 28 f., the largest I had (with the intention of driving it in rapidly as soon as the stricture was reached), without meeting the slightest resistance, it went squarely into the bladder. Ten days after he called at my office, with an account of an attack of chills and fever (to which he had previously been subject) following the operation, and stated that he "had had no urinary trouble since, and could "pass a strain as large as his finger." In order to test this case (as the rupture, if it was such, had been done with 28 f.), I passed in a 32 f. solid sound, which slipped without resistance through into the bladder. Up to this time (six months from the date of operation) he has remained perfectly well.

*Case 5.* — In February, 1874, I received a letter from a surgeon, asking advice as to the propriety of operating with my dilating urethrotome upon a stricture in the membranous urethra. "The stricture," he wrote, "is seven inches from the meatus. By using a small, pointed bougie it can be passed, and then easily dilated to 14 of the English scale. In this condition it has remained for several months. Interference with and frequency of urination are his chief troubles. The stricture is to a great extent spasmodic, as, sometimes, it will hold a small instrument with great firmness. Sometimes I have thought there might be the commencement of a false passage, the difficulty of getting an instrument engaged was so great." I wrote, suggesting the careful examination for an organic stricture in the anterior portion of the canal, which by irritation, either from passage of urine or urethral instruments, might cause the deeper trouble. In an answer, a few weeks after, he stated that he had found some contraction at the meatus and had divided it, but with no effect upon the deeper trouble. May 12 he called with his patient. Examination showed contraction at the meatus not fully divided. Twenty-nine f. only would pass, while the normal urethra was at least 31 f. Two other strictures were detected, at two inches, with 29 bulb. Twenty-nine solid steel sound was readily passed to the bulb, and notwithstanding gentle pressure for several

minutes against the face of the stricture, it would not advance. I then divided the stricture at the meatus freely, also the deeper bands; immediately following which, a 31 solid sound passed, without the least resistance, through into the bladder.

*Case 6.* — W. W., a surgeon of this city, aged 62, came to me in the evening of December 18th, suffering from an attack of retention of urine. He was in a state of great nervous excitement, and was bleeding, somewhat freely, from the urethra, as a result of attempted passage of instrument. His history was as follows: First gonorrhœa at 19 (1832), repeated attacks up to 1857, at about which time he began to experience some difficulty in urinating. This, within a short time, became so marked that he sought assistance from a surgeon of great experience and skill. He was found, after a careful examination, to have an organic stricture at the bulbo-membranous junction, size No. 3 of the English scale. During the following three months he was systematically treated by the use of flexible bougies, until No. 12 of the English scale (17 f.) was reached. The solid steel sound was then substituted, and he was directed to use it three or four times a month, *as long as he lived*. He did so for a few months, and then neglected it for a year; when, his urination becoming very slow and troublesome, he attempted to pass his No. 12. He succeeded, by patient effort, in making a false passage, but failed in entering the bladder. He then recommenced with No. 2, and dilated his urethra gradually, in a few weeks, to No. 12 again. The habitual, semi-monthly use, of this size was kept up for the next 15 years, and up to three years since. He then increased the interval to one month, until finding, after often waiting half an hour at a time, that he was obliged to use gradually decreasing sizes, down to No. 5, and besides suffering much from frequency and urgency in micturition, he became discouraged with his efforts, and concluded to do no more, until an attack of retention (with which latterly he had often been threatened) should occur. In this event, he proposed to have the canal restored by a cutting operation. For the past five years he had suffered with frequent chills and fevers, which, notwithstanding a full treatment by quinine and arsenic, he failed to cure. He was habitually passing his water in a small irregular stream, every 30 minutes, on the average, during the day, and five or six times during the night. A cursory examination showed that there was no great amount of water in the bladder. In view of the injury that had already been done to the urethra, and the probability that there was a fresh false passage, I prescribed Tr. Mur. Ferri., in 10 drop doses every hour, a suppository of morphia sulph.  $\frac{1}{4}$  gr., and rest in bed, assuring him that there was no serious trouble, and that, in case his retention gave him pain during the night, I would at once come and give him relief.

neither saw nor heard from the doctor until Christmas Day, just one week from the date of his previous visit. He then presented, in very good general condition, and stated that after leaving me with his retention, he went home, passed a good night, and in the morning urinated as usual (except in larger quantity), and since then had been about as before the attack. He had now come to ask an engagement for the radical operation on his stricture.

It was with the greatest reluctance that he consented to an examination, on account of his apprehension of pain. He was certain of the locality and extent of his stricture, and begged that the examination and operation should be done both at once, when under ether. The circumference of the penis was three and a half inches, indicating a normal urethral calibre of at least 34, of the French scale. Size of meatus, 28 f. I then, with assurance of desisting at the least discomfort, began the gentle introduction of 28 f. conical steel sound. As the instrument passed along the pendulous urethra, it was distinctly resisted in its advance and grasped at a number of points, finally reaching the membranous portion. At a moment when his attention was purposely distracted from his urethra, I slipped the sound easily, and without the least force, *through it and well into the bladder*. The blank astonishment of the doctor may be better imagined than described. On the removal of the sound (which in the act of so doing was closely held), he exclaimed: "So this is the organic stricture I have been systematically dilating, and making false passages around, for the last 20 years! It is impossible. Why should my stream be always so small, and my urination be so frequent? Doctor" (with alarm), "are you quite sure that the instrument *did not go through a false passage and into the abdominal cavity?*" I then demonstrated, by means of a 28 f. bulbous sound, the presence of a stricture half an inch in length, commencing at the external opening of the urethra. I explained the occurrence of the frequency and difficulty of micturition, and the resistance to instruments, by attributing it to a *reflection of the irritation from the point of true stricture at the meatus, to the compressores urethræ*; this, causing a firm, persistent closure of the urethra, at the membranous portion, as often and as long, as urine was brought in contact with it, or instrumental passage attempted. In an examination with the urethra-meter, I found two more bands of stricture, at two and two and a half inches, of the value of 30 f. It was, however, to the single stricture, at the meatus, that I attributed the spasmodic trouble.

January 10.—Dr. — presented for an operation on the anterior stricture. Present, by my invitation, Prof. Willard Parker, Dr. Gurdon Buck (to whom the patient was professionally well known), Drs. Stimson and W. Parker, junr. The history of the case was recounted, and the difficulty claimed to be dependent upon irri-

tation, reflected from the anterior stricture alone. Local anæsthesia by the spray of ether was induced by my assistant, Dr. Fox. I then divided the stricture thoroughly, and introduced 34 f. bulbous sound through it, and down to the first slight contraction at two inches; size 30 f. 30 f. solid steel sound was passed easily to the bulbo-membranous junction, when it caught, evidently in a false passage; 28 f., with slightly different curve, was then passed easily into the bladder; 30 f., of same curve, followed it without difficulty.

Up to the hour of the operation, the patient passed his water, at least every half hour, on the average. Subsequent to it, he did not pass it for 10 hours, and then in full, steady stream. At the end of a month, when I saw him, his average interval between the acts of urination was eight hours.

There are several points in the foregoing cases (which I think may be fairly claimed as types of a class) which coincide with the accepted characteristics of true, deep organic stricture, and which, if not appreciated, would lead, of necessity, to an erroneous diagnosis, such as was originally made in each one of the cases reported.

1. *A gradual diminution of the stream of urine.*
2. *Persistent frequency of micturition.*
3. *Persistent resistance to the introduction of large instruments in the hands of skilled surgeons.*
4. *Distinct grasping of small instruments, and a gradual toleration of instruments of increasing size, and, in this, so perfectly simulating the behavior of true organic stricture, that the most skilled and learned surgeons have been deceived by these conditions.*
5. *The persistence, during a long period of years, of all symptoms which are recognized by authorities, as characteristic of organic stricture.*

“The grand distinguishing feature,” says Sir Henry Thompson,\* “which marks the phenomena (of spasmodic strictures), and by which they are contrasted with organic strictures, is their *transitory character.*” So says, in effect, Mr. Erichsen, Dr. Bumstead, Drs. Van Buren and Keyes, Drs. Stilling, Dittel, etc., leading teachers and authorities in such matters.

\* Op. Cit., p. 140.

Now, if this is *not the fact* (and that it is not, the cases cited go to prove), it will be readily seen that those surgeons who differentiate organic from spasmodic strictures by what is claimed to be "the *distinguishing feature*, viz. the *transitory character of spasmodic stricture*," are liable to fall into the grave error of treating a reflex urethral spasm for organic stricture. It is not at all likely that the six cases I have reported, in which this error was made (in *four* cases by *none* who did not fully understand and appreciate *all the points* which Sir Henry Thompson and Mr. Erichsen and others so explicitly lay down for guidance in such cases), I say it is not *likely* that these are *all* the cases in which such errors have occurred, or are likely to occur. They are *types of a class*, and a large one too, which will necessitate the acceptance of *other* means of diagnosis than those now in vogue, before such errors can with certainty be avoided. First of these, is the necessary knowledge of the *normal calibre* of the urethra, in which symptoms of stricture are present; second, *the size and condition of the external opening*. If the measurements of these two points do not completely correspond, there is reason to believe that a reflex irritation may be present, which has the power of obscuring diagnosis. If there is a stricture, at or near the meatus urinarius, acquired through a previous gonorrhœa or of congenital origin, contact of urine with the sensitive mucous surface (which is always present behind such stricture), or contact of exploring instruments, is capable of exciting a spasm at the membranous portion of the urethra; a spasm which will often *persist* even when the patient is fully anæsthetized; and will continue up to the time that a *complete* division of the stricture is effected.

It may, I think, be safely claimed that no reliable examination of the deeper urethra can ever be made while a *stricture*, or even an *erosion*,\* is present in the anterior portion of the canal. Inferentially, then, no *treatment* of deep stricture, *per se*, should be attempted, until the *complete* freedom from organic contraction of the anterior portions of the urethra, is established. A long series

\* Thompson Op. Cit., p. 132.

of careful observation of the urethral calibre (by the aid of the *urethra-meter*), have conclusively demonstrated a nearly uniform relation between the size of the urethra and that of the penis in which it is located. As I have stated in other papers on this subject, that the circumference of the presenting penis being three inches, the normal urethral calibre will correspond to 30 or more of the French scale: if three and one-fourth, to 32 or more; if three and one-half, to 34 or more; if three and three-fourths, to 36 or more; if four, to 38 or more; if four and one-fourth, to 40 or more.

When the *urethra-meter* is not available, a urethral calibre based upon these calculations may be implicitly relied upon, as not over estimated; on the contrary, it will often be found one or more millimetres below. Urethral examinations with a *bulbous sound*, corresponding in size to the normal urethral calibre, *alone* can demonstrate complete freedom from stricture in any given case. The presence of the slightest contraction at any point, may be accepted as capable of producing reflex irritation, which may result in spasmodic contraction, which shall possess all the recognized characteristics of a deep organic stricture.

108 WEST 34TH STREET, *March 22, 1875.*

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## A NEW CLINICAL CLASSIFICATION OF DISEASES OF THE SKIN.\*

BY HENRY G. PIFFARD, M. D.,

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TO gentlemen as familiar as yourselves with the various classifications which have from time to time been proposed, it would be altogether out of place in me to give a comprehensive or detailed account of the labors and results of the past. We all

\* Read before the New York Dermatological Society, December 8, 1874. (The classification was referred to a committee to examine and report on, at a future meeting of the Society. ED.)

know that the older classifications may be placed in three divisions, namely: those which, in the first place, arranged the various diseases in accordance with their external aspects; the plan adopted by Plenck, Willan and others. Secondly, those in which the affections were arranged according to the particular pathological processes involved, as the classifications of Hebra, Neumann and the earlier classification of Wilson. Thirdly, those which, with a wider and, I think, more philosophical aim, sought to arrange and classify these affections in accordance with their real nature and prominent clinical resemblances. The effort to construct a classification upon this basis was attempted by Alibert, but the plan proposed by him was in many of its details so fantastic and bizarre, that it met with very little encouragement, even in France. A greater measure of success, however, attended the efforts of Hardy and Bazin, who likewise sought to classify these affections after a natural system and upon a clinical basis, and the ideas and principles enunciated by these investigators furnish the key-note of the French dermatology of the present day.

The writer, early impressed with the desirability of system in the *envisage* of cutaneous as well as of other affections, and after a careful consideration of the merits and demerits of the prevalent methods, is forced to the conclusion that the French idea, that of a natural or clinical classification, offers the greatest advantages, whether considered from the standpoints of the student or the teacher. Believing, then, that this method affords the greatest assistance, whether the object be to acquire or to convey a comprehensive knowledge of cutaneous affections, and desiring to facilitate their study, I venture to offer for your consideration a new Clinical Classification.

This classification I believe to be correct in principle; but in matters of detail, doubtless leaves room for improvement, and I hope that a free and candid discussion of these latter points may result in desirable modifications of the proposed plan.

In this view, I have arranged the various cutaneous affections in five principal groups.

- I. GENERAL DIATHETIC AFFECTIONS.
- II. GENERAL NON-DIATHETIC AFFECTIONS.
- III. REFLEX AFFECTIONS.
- IV. LOCAL AFFECTIONS.
- V. AFFECTIONS OF UNCERTAIN NATURE.

*General diathetic affections.*— This class embraces the cutaneous affections which are the outward manifestations of a general morbid constitutional condition or diathesis, which diathesis may be hereditary or acquired, and lasts indefinitely and often for life.

*General non-diathetic affections* are those which occur during or in consequence of a general morbid condition, not hereditary, and of temporary duration.

*Reflex affections* include those which depend directly upon nerve lesion, or else occur through the medium of reflex action as secondary to pre-existing disease or derangement of other organs.

*Local affections* embrace those which have no direct connection with abnormal conditions of the blood or viscera.

*Diseases of uncertain nature* embrace all the affections which our present knowledge will not permit of placing in the other classes.

With these preliminary remarks, I present the detailed arrangement which I have temporarily adopted.

In the class of DIATHETIC AFFECTIONS I place the following:

<p><b>SYPHILIDES.</b></p> <p><i>Varieties.</i>— Erythematous.</p> <p style="padding-left: 20px;">Papular.</p> <p style="padding-left: 20px;">Tubercular.</p> <p style="padding-left: 20px;">Vesicular.</p> <p style="padding-left: 20px;">Bullous.</p> <p style="padding-left: 20px;">Pustular.</p> <p style="padding-left: 20px;">Squamous.</p>	<p>Tubercular.</p> <p>Phlegmonous.</p> <p><b>RHEUMIDES.</b></p> <p><i>Varieties.</i>— Eczema.</p> <p style="padding-left: 20px;">Psoriasis.</p> <p style="padding-left: 20px;">Pityriasis.</p> <p><b>LEPROSY.</b></p> <p><i>Varieties.</i>— Tubercular.</p> <p style="padding-left: 20px;">Anæsthetic.</p> <p><b>ICHTHYOSIS.</b></p>
<p><b>SCROFULIDES.</b></p> <p><i>Varieties.</i>— Erythematous.</p> <p style="padding-left: 20px;">Corneous.</p> <p style="padding-left: 20px;">Pustular.</p>	

With reference to the foregoing, it is proper that I should briefly refer to some of the points which may seem peculiar. None will deny the diathetic nature of the syphilides, and but few, I believe, will contest the constitutional nature of the scrofulides; but many, and especially those imbued with the doctrines of the Vienna school, will question the propriety of associating eczema, psoriasis and pityriasis under the common title which I have given them.

The Rheumides, it will be seen, are the affections which the French dermatologists include under the terms Dartres or Herpetides. Accepting the arguments which have been offered in support of the reality of this, Dartrous, Herpetic or, as I prefer to term it, Rheumatic diathesis, I shall not at present add to them, other than to call attention to some of the characters common to the affections embraced by it.

*Common characters of the Rheumides.*—They are not contagious; they are frequently general, not, however, by simultaneous invasion of the surface, but by spreading from different foci: they are frequently symmetrical; they are usually chronic; their natural duration is indefinite; they are obstinate and do not readily yield to treatment; they are frequently observed in different members of the same family; they are frequently observed in different forms, in different generations of a family; two or more forms may be present at the same time, or may appear successively; relapses are frequent; they sometimes alternate with affections of other organs, especially of the pulmonary and gastric mucous membranes and of the joints; they itch; the lesions are always superficial; they never leave cicatrices; they are more or less amenable to certain definite methods of treatment, which have little, if any, effect upon other cutaneous affections.

The special names, Rheumides and Rheumatic diathesis, have been selected in consequence of their etymological signification, which implies the idea of exudation;\* secondly, because the blood condition underlying this diathesis I believe to be similar to, if

\* Hebra includes these affections in his class "Exsudate."

not identical with, that concerned in the production of rheumatism and gout; and thirdly, because the vulgar name, Salt Rheum, so commonly used in this country, implies the same idea. I have not adopted the French name Dartre, as it would be utterly without signification to the English or American mind, and the term *Herpetic* is used by us in a sense entirely different from that in which it is employed in France.

Among the NON-DIATHETIC AFFECTIONS I include

Eruptive fevers.	Erysipelas.
Scorbutus.	Glanders.

The REFLEX AFFECTIONS embrace

Acne.	Pemphigus (?)
Gutta rosea.	Xanthoma (?).
Urticaria.	Chloasmata ( <i>some</i> ).
Zoster.	Dermatalgia.
Herpes labialis, prepul-	
tialis, etc.	

I have placed Acne and Gutta rosea in this group in consequence of the belief that, in the majority of cases, if not in all, they are dependent upon pre-existing disease or derangement of the digestive or sexual apparatus.

The position of Urticaria, Zoster, Herpes labialis, etc., will not be contested.

Pemphigus I have marked doubtful, as although it is the fashion at present to include it among the neuroses, the evidence in support of this idea is far from convincing.

Xanthoma is also marked doubtful, but is placed here in consequence of its frequent known association with hepatic disease.

The "some" cases of chloasma include the "maculae gravidae," etc., dependent upon uterine trouble.

The LOCAL AFFECTIONS embrace

A. PARASITIC.

Scabies.	Pityriasis versicolor.
Phtheiriasis.	Alopecia areata (?).
Favus.	Impetigo contagiosa (?).
Trychophytosis.	

## B. NON-PARASITIC.

Ephelis, Fuscedo.	Intertrigo.
Effects of heat and cold.	Nævus.
Effects of chemicals	Sudamina.
Effects of poisonous plants.	Furuncles and Anthrax.
Effects of poisonous insects.	Verrucae.
Clavus, Callus.	

The position of the first five affections in this group will not be contested.

Alopecia Areata in spite of the opinions of Bazin, Fox and others and the recent investigations of Malassez,\* must, I think be still considered as of doubtful parasitic nature.

I have also marked Impetigo contagiosa doubtful. The phenomena exhibited by this affection, and my own microscopical investigations,† incline me to believe in its parasitic nature; but I do not consider this to be absolutely proven.

The fifth and and last group embraces the

## AFFECTIONS OF UNCERTAIN NATURE.

Albinismus.	Prurigo ( <i>of Hebra</i> ).
Nigrismus.	Rhinoscleroma.
Vitiligo.	Scleroderma.
Keloid.	Scleriasis.
Lichen ruber and planus.	Strophulus.
Molluscum.	Erythema.
Morphœa.	Pellagra.
	Elephantiasis arabum.

The list of affections in this group is long; but it is to be hoped that the rapid advances in dermatology, which are now being made, will permit of the transference of some of them to other classes.

\* Archives du Physiologie, 1874.

† New York Medical Journal, June, July, 1872.

## INUNCTION AS A REMEDY IN MEASLES.

BY J. L. MILTON,

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SEVERAL years ago I endeavored to introduce into England the plan of treating scarlatina recommended by Dr. Schneemann of Hanover, which consists principally in rubbing the patient well over with fat. The attempt met with but little response, and I believe the recommendation in my work on diseases of the skin to extend the same treatment to measles has proved utterly fruitless. I therefore thought that a few remarks on the subject might be a suitable contribution to a journal intended to diffuse information on such points.

On the 13th of December, 1873, I was requested to see Miss Eleanor W. Her parents were much alarmed about her, as she had contracted measles and the disease had suddenly assumed a severe form. I may mention that at that time measles was very prevalent and fatal in the neighborhood. Her two brothers, younger than herself, were also thought to be sickening with the same complaint. On my arrival I found the girl evidently sinking. Stimulants were freely given, but did no good; the child rapidly passed into a state of almost total unconsciousness, and died within about eleven hours.

The two boys being placed under my care for the same complaint, from which they were undoubtedly suffering, I directed the mother to procure a large piece of fat bacon, to soak it well in cold water, and then place it in the oven. As soon as it began to melt she was to take it out, rub the children all over with it from head to foot, and leave them lying in the grease. The friction was to be repeated night and morning, and the children were not to be washed at any time. The diet was to consist of slops, containing, however, as much beef tea, made with cold water, soup and broth, as the children could be induced to swallow. The only medicine ordered was carbonate of ammonia, in tolerably full doses for children, and an occasional dose of salts and senna. In both these cases the disease was somewhat severe, and in both there was the additional complication of an unhealthy

constitution; the elder boy, who was about five years old, having long suffered from eczema, often aggravated by large ecthymatous pustules. Both recovered perfectly.

The children of some friends of the family, staying in the house, who had either contracted the complaint as an epidemic or had caught it from the girl, having been in the same room with her while she was ill, were placed under my care on the same day as the two brothers. Both were put under inunction at once, and went through the disease very satisfactorily. It did not, however, present any symptoms of gravity in either.

Some time after this I was attending Miss W. She was a thin, delicate, fretful child, about three years old, and had suffered much from whooping cough, then also very prevalent in the neighborhood, and from eczema for which complaint she had been placed under my care. I had only seen her a few times when, on the 22d of May, 1874, she was attacked with measles, and directly after her two brothers, both very little older than herself, were laid up with the same disorder. The eruption came out most copiously in her and the younger boy, and was in both accompanied by very marked catarrhal and bronchitic symptoms, followed by great soreness and abrasion of the lips and insides of the cheeks. In the elder boy the symptoms were much milder. All three were kept covered with fat, and treated with ammonia every four hours, aided by gentle aperients, till the soreness of the mouth set in, when chlorate of potash was substituted in the case of the two younger children. In these the disease ran its course with such severity that I more than once despaired of their lives. For two days and nights I thought the girl would sink, and I believe she was only kept alive by brandy and beef tea, administered both by the mouth and rectum, for at times she could not be induced to swallow any thing. Scarcely had she begun to rally when it seemed as if the younger boy would succumb. Brandy in beef tea was given in his case even more freely than in that of the girl. All three children did well, though they were all three extremely delicate and looked ill-fed, which, however, was not in any way due to want of good food. There were no other children in this family, neither were there in the first mentioned. Both sets of parents were themselves delicate, and in both cases the children seemed to have inherited very feeble constitutions.

The next set of cases presents even greater complications than either of the foregoing. The parents were young, strong, healthy

people. They had six children. The oldest, a girl about eleven years old, had long been living in the country on account of delicate health, and "breakings out," which I afterward found were eczematous. She did not return to London till some time after the date of this narrative. After her came three boys, all highly delicate. The two oldest had been reared with great difficulty, and the oldest of all had, on one occasion, nearly lost his life from bronchitis. This was the first member of the family that I was called on to attend. The two remaining children were girls; one a finely made, sturdy little thing, the other a healthy infant at the breast.

I was first consulted respecting the oldest boy on the 10th of March, 1874. He had been ill for several weeks with whooping-cough, complicated by a certain amount of bronchitis. My advice, however, was sought chiefly with respect to an outbreak of eczema, which extended outward and downward from the right nostril over the lip, attended with great swelling of the latter. I put him on tonic treatment, but within three days from my first visit he was seized with measles. The second boy, who had also been very poorly with whooping-cough and some bronchitis, was taken ill directly after with measles. Then the youngest son, who had likewise had whooping-cough very severely, but had escaped bronchitis, was assailed by the epidemic, and almost coincidently with him the little girl. She had had whooping-cough for some time, but never to such an extent as the other three, whose sufferings were distressing to witness. I scarcely ever entered the house without either finding one at least of them in a paroxysm, or seeing an outbreak while there. The baby, who had a cough, escaped the measles.

All these children were treated with friction, ammonia and chlorate of potassa, very gentle aperients being administered every two or three days. The eruption was very mild in the girl; the boys were all very ill. The event was favorable in every case. The mother, a most devoted nurse, carried out all instructions as to rubbing in the fat, medicines, diet and ventilation, with a minuteness which left nothing to wish for. As soon as he could be safely moved, the second boy, who had been very much prostrated by these repeated illnesses, was sent into the country, so that only four children remained at home.

Toward the end of May, the oldest boy had again begun treatment for the eczema, which, so far as I could observe, had remained unaffected by the measles, only, however, to be again interrupted by a strange fatality; for, on the 2d of June, I was requested to see him, and, on arriving, found him suffering from scarlatina (anginosa). At my request, the parents immediately removed the youngest girl and boy to a cottage at a considerable distance. The baby, who could not be removed, as the mother was suckling it, speedily showed symptoms of scarlatina. The boy was treated with inunction, *being the second time within three months that he underwent this process.* He was very ill, but struggled through it all. The baby was treated like the rest; it was very ill for two days. The children who were sent to the cottage escaped scarlatina. Before they returned home, the house was thoroughly disinfected. I advised that every ceiling should be whitewashed, the walls stripped and washed with solution of chloride of lime prior to being re-papered, and that every thing in the shape of bedding and clothing should be subjected to the fumes of burning sulphur and chlorate of potassa. This was done, and the servant who had nursed them was sent into the country for a long holiday. The second boy, who came back shortly after, has never shown any signs of scarlatina, and the eldest child of all, who followed him home, has also remained free.

Dr. Schneemann holds that inunction lessens the danger of infection being conveyed from the patient, and there is a certain amount of evidence that such is really the case. I do not know whether the immunity extends to the room, bedding and so on. The experiment would be an unjustifiable one to make, and I can only offer, on this head, one or two scattered observations incidentally forced upon my notice. Certainly there seenis some reason to think that the air of the apartment in which the patient lies is less tainted when inunction is resorted to. I do not say that the facts pointing to such a conclusion are in any way decisive; but that, so far as they go, they seem to warrant such an inference; and as this part of the subject is almost of more importance than the treatment of the disease, I will take the liberty of at once citing the two or three cases of which I have just spoken, which were principally collected during the late

epidemic of scarlatina in London, and about the accuracy of which I could satisfy myself as fully as any thing I can well conceive.

A young lady, about nine years of age, was attacked with scarlatina. I attended the family, but was away at the time. I had previously had this child and her only sister, two years younger than herself, under my care for measles, and had treated them with inunction. The mother seemed highly amused at the idea of my ascribing an importance to this part of the treatment; but so soon as she heard from the medical man called in that her daughter had scarlatina, she took the law into her own hands, and, without saying a word to him, rubbed the fat in night and morning; a feat upon which she praised herself highly. The other little girl played about in the same room with her sister nearly all day, and slept in a room only divided from hers by a folding door always open. She did not take any infection, though, as a rule, she suffered more in these matters than the elder sister. This was the case in the attack of measles spoken of, and also in one of continued fever. Subsequently, too, when both were laid up with varicella, the younger sister had much the worst of it.

I attended Master B., about ten years old, for scarlatina. He was treated by inunction, and was so situated as to be able to spread the disease far and wide, for his mother, who employed several workwomen and girls, could not leave her work and yet would not let him be out of her sight. Consequently he was placed in a room opening directly upon the workroom. The communication between the bed-chambers was unbroken, night and day; but I never could learn that any of the girls or work-women took the disorder or conveyed it to any member of their families. Almost at this very time a surgeon, who had been summoned to the country on urgent family matters, asked me to see some of his patients during his absence. Among them was a boy just recovering from scarlatina, who had had the disease in quite as strongly marked a form as the last patient, but who had not been treated with friction, and who, when I saw him, had been playing about more than a fortnight. Three days after this, or more than seventeen days after what might be considered complete recovery, he was sent back to the boarding school. Although every precaution in the way of cleanliness was taken with respect

to this lad's clothing, I was informed that he gave the disease to thirty-two of the boys of the school, a statement, however, which I had no means of verifying.

On the 2d of April, 1874, I had to visit a young lady supposed to be ill of scarlatina. I found this was so, and that the symptoms were of sufficient importance to excite great uneasiness. I recommended inunction in her case, and that the other children should be separated from her, a recommendation which was immediately carried out. She made a good recovery, and did not come in contact with any of her brothers and sisters for quite a month after she had left her bed. She did not appear to convey the disease to any of them, but two of the children who had played in her bed-room, after it was supposed to be disinfected, the process being, I feared at the time, very inefficiently carried out, were assailed by scarlatina. Isolation was again resorted to, and no more cases occurred. Both children were treated on the inunction method.

I do not seek to prejudge the issue of this question, but it seems to me that the evidence is in favor of the system as regards both prevention and cure. The proper plan, however, of really testing a remedy is to try it in the sick room, and I shall be highly pleased if inunction should receive a fair trial at the hands of some of the many enlightened and impartial practitioners to be found in America.

Supposing its value should be confirmed, what becomes of the hypothesis of blood poisoning and elimination in scarlatina and measles? Unless the body could be varnished from head to foot, it is difficult to imagine how the expulsion of the peccant matter, the *materies morbi*, could be more effectually checked than by sheathing the surface in fine fat. The humoral doctrine proves, beyond cavil, that such a step ought to be followed by the most serious consequences, yet so far as I can see, nothing of the kind takes place. Humoralism possesses a marvellously elastic nature, it is capable of adapting itself to the most awkward emergencies, but it seems to me that it has been an ugly difficulty to encounter.

LION HOUSE, KINGS ROAD, }  
London, England.      }

## Clinical Reports.

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*A case of syphilitic disease of the auditory nerves (or cochlea), diagnosed by means of the eruption; specific treatment; recovery.*  
By D. B. JOHN ROOSA, M. D., Professor of Diseases of the Eye and Ear in the University of the city of New York.

Mr. X.,  $\text{\textit{A\acute{E}t. 37}}$ , was sent to me on October 28, 1874, on account of a great impairment of hearing, for which his physician was unable to find any adequate objective symptoms. The patient was a healthy looking man, and gave the following history: Five weeks ago he had become very suddenly, "in one day," very hard of hearing; this loss of hearing was accompanied by very considerable noise in the ears. Since then he has been getting worse, until he cannot carry on his business, which is that of an insurance broker, and he voluntarily remarks that he is much worse at night.

On testing the hearing power, it is found that the watch is not heard at all on the right side, ( $\frac{0}{40}$ ") and only when laid upon the left auricle ( $\frac{1}{40}"), the tuning fork is heard more distinctly in the ear, on which the watch is heard. The pharynx is granular, and secreting in excess. The drum-heads look well, except that the light spots are small. Air enters both tympanic cavities by the catheter and Politzer's method, but no improvement in hearing power results from the inflation of the ears. The *tuning fork* and the negative results of the treatment of the middle ear, which had been carried on by the surgeon who sent the patient to me, enabled me to diagnosticate this as a nerve lesion; but the cause was not quite clear. I observed an eruption, papular and diffuse in character, on the palms of the hands and the wrists, and that the scalp looked as if the hair had fallen out; but as the wife of the patient was in the consulting room, and eagerly watching the examination, I postponed further inquiries until the next day, when the patient re-appearing alone, I asked him "when he had a chancre?" or, "when he had a venereal disease?" He replied, in March, '74; further inquiry elicited alopecia in July, and an eruption for the last few weeks. The specific character of the lesion was then plain, and I put him upon Mercurial Inunction and Iodide of Potassium, under which he steadily recovered his hearing power, and lost the tinnitus aurium. I saw him again on December 28, when his hearing power was$

expressed by the fraction R  $\frac{\text{Pressed}}{40}$  L  $\frac{6}{40}$ ; since then I am informed (in February, '75) by his physician, that he had still greatly improved. If the patient had not been a person of excellent reputation as to marital fidelity, his own physician, from whom he had concealed his lapse from virtue and its resulting chancre, would have discovered the cause of his loss of hearing.

The exact seat of the lesion, that is, whether the trunk of the nerve or its expansion into the cochlea, can only be conjectured. That the lesion was not a periostitis of the *meatus auditorius internus* may be concluded, I think, from the absence of pain. The shortness of the time from the initial lesion to the appearance of the impaired hearing, also argues against a gummy tumor. Serous exudation between the fibres of the nerve or upon its thread-like expansion in the cochlea, seems to me a probable lesion in this case.

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*Hæmorrhage from the ear, with purpura.* By THOMAS R. POOLEY, M. D., New York.

That hæmorrhage should take place from any mucous membrane, in the condition of the blood consequent upon purpura, is not surprising. And yet, so far as I know, its occurrence from the ear in this disease has not been reported. It cannot therefore be without clinical interest to briefly report the following case, which came under my observation:

The patient, a little girl æt. four years, was under my care at first, in the New York Ophthalmic and Aural Institute for a chronic inflammation of the middle ear, with perforation of the membrana tympani, and otorrhœa of the right side, a sequel of measles which she had when one year old. Under appropriate remedies the otorrhœa ceased, and treatment was discontinued.

In regard to her antecedent history, I learned that her paternal grandfather died from phthisis, and that she had been subject, since she was one and a half years of age, to fainting fits, occurring about every two months.

The patient came under my observation again February 9th, 1874. I was at once struck by her extreme pallor. Her mother told me that, about three weeks since her ear began to discharge again, and that lately the discharge was tinged with blood. And the hæmorrhage had increased to such an extent as to make her weak from loss of blood. She had also had several attacks of epistaxis. Upon examination, I found the external meatus stained with blood, and an oozing from the auditory canal; there was

hardly any purulent nature to the discharge. After syringing the ear, and examining with the mirror, a large perforation of the membrana tympani was seen, with a slightly granular condition of the cavitas tympani ; thin, watery looking blood could be distinctly seen oozing from the mucous membrane. While considering what could be the cause of the hæmorrhage, my attention was directed to several large greenish looking spots on the forehead (evidently of an hæmorrhagic character) ; on further inspection, I found numerous other spots of the same kind on the extensor surface of the extremities, and over some bony prominences on the trunk. Besides these, there were numerous other smaller petechial spots scattered over the entire body, but in the greatest number on the inferior extremities. They were of a deep red color, not perceptibly raised, did not shade off at their circumference, and gave rise to no abnormal sensation.

On looking into the throat there were several patches of hæmorrhage under the pale mucous membrane on the roof of the mouth. The gums were soft and spongy, and watery blood oozed from their margins. The treatment employed was instillations into the ear of dilute perchloride of iron, and syringing with cold water ; with iron, quinine, and generous diet. I saw the child only once more, on the following day, and am indebted to a friend for the continuation of the history, which is necessarily incomplete, as he kept no notes of the case, and was unable to refer to dates.

The hæmorrhage from the ear became more profuse ; the gums were spongy, and blood constantly exuded from them. A swelling appeared on the right side of the lower jaw, over the last molar tooth ; it gradually broke down, with hardly any suppuration, discharging a bloody fluid and detritus. The temperature of the body was raised ; the complexion changed to a yellowish tint ; and several hæmorrhages from the mouth, but only small in quantity, occurred. A few days before death ensued, respiration suddenly became very rapid, the temperature greatly increased, but there was no dyspnœa. Percussion gave marked dullness of the lower part of the right lung posteriorly, and slight dullness of the left side. There were no râles, but increased vocal resonance and tubular breathing on the right side. The child had retained perfect consciousness up to this time, but now became semi-comatose with dilated pupils, and died the evening of the same day, consciousness having returned a few minutes before death.

Her mother told me that they lived in the basement of a rear house. The attending physician says, however, that it was not much below the level of the street, and not particularly damp, nor had the patient been deprived of good and sufficient food. The cause of the purpura was therefore obscure. The other ear was quite normal.

In this case, the swollen condition of the mucous membrane of the tympanum, and the almost complete absence of the membra tympani, were favorable conditions to the occurrence of haemorrhage from the ear. Might it not just as well occur, in such a condition of the blood as we have in this disease, where there was no perforation of the drum-head, and cause a collection of blood in the tympanic cavity, which should break through this membrane? It may not be without interest to add that a case has recently been reported by Dr. Adler\* of a patient presenting all the symptoms of scorbutus, in which the sight was abolished by a spontaneous haemorrhage into the anterior chamber of the eye. Medication, directed against the general affection, brought about complete absorption of the blood, and restoration of sight.

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*Unusual form of bone disease resulting from Syphilis.* By T CURTIS SMITH, Middleport, Ohio.

Jane H.,  $\text{\textit{A\acute{E}t. }} 12\frac{1}{2}$ , small for her age, apparently stunted in growth, sallow complexion, black eyes and hair, eyes small, hair coarse, bones small, flesh thin, and is nervous and anaemic. I found that the right side of the cranium was apparently larger than the left, the enlargement commencing at the median line in the frontal bone and extending posteriorly along the sagittal suture to the superior angle of the occipital bone, where it fell off abruptly; from this point the thickening could be distinctly traced along the border of the parietal bone to its junction with the mastoid portion of the temporal; from this point forward it could be distinctly traced to near the middle of the squamous portion of the temporal bone, when it graded off so evenly as to render it impossible to trace it farther; but in coming forward to the external angular process of the frontal bone, the thickening was again distinctly felt, and could be traced from there backward nearly an inch. The thickening evidently involved the supra-orbital ridge and orbital plate of the frontal bone, as it was plain that the right eye was crowded forward, and thus was made to appear larger and more prominent than the opposite eye. The line marking this enlargement was abrupt and distinct throughout nearly its entire course, and the thickening of the right side of the cranium gave the head

\* Scorbatic Hæmophthalmos. Extract from the annual report of the Weiden Hospital etc., by Hans Adler, in Annales d'Oculistique, Sept. and Oct., 1874.

and forehead the appearance of having grown faster than the left. That the thickening was all on the external surface seemed clear, and I think it was a proliferation of tissue, from disease of the periosteum covering the bones involved. There had been no reason to suppose there was any internal thickening, as the child had no manifestations of epilepsy, chorea, paralysis or pain. The use and sensation of both sides were alike, and development was symmetrical in all parts except the head. I looked upon the condition before me as one of the very many and varied forms that Syphilis will produce, and that the whole enlargement was produced by ossific thickening from proliferation of bone tissue resulting from a morbidly affected periosteum.

My reason for this conclusion, whether correct or not, was as follows: The child had the peculiar appearance that syphilitic children so often present; her teeth were uneven and notched, nails brittle and broken off half way up to their roots, and were uneven in thickness; there were also numerous glands about the neck that were enlarged and hard, feeling like large shot under the skin. To these conditions I was able to add the weight of evidence from the parents. The mother was evidently suffering from constitutional syphilis near the time of the child's birth, as her history as given by herself proved, and the father was of known dissolute habits, and had, as he acknowledged, been infected with syphilis some 14 to 15 years before. The mother had had three miscarriages before the birth of this child, and one birth at term, the child dying when two weeks old. Besides, both parents had passed through the eruptions, etc., of the second stage of syphilis, and both could distinctly refer to the times when they had some painful disease of the bones.

The child did not seem to suffer from the condition of its head, and was only treated because she was weak and anemic. I gave her Ferrum Redactum with Quinia, and Hydr. Bichloridum, from which she seemed to improve in strength, the glandular enlargement disappearing, but with no impression of the cranial enlargement.

## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. BULKLEY.

*Fifty-eighth Regular Meeting, June 9, 1874.*

DR. STURGIS mentioned having seen the typical notched teeth (the two upper incisors), as pictured by Hutchinson, in a child where there was no syphilitic history and no symptoms of the disease present. The child was aged 16 months, with deciduous teeth, therefore, and has perhaps, 16 others healthy. It is the youngest of three children; the oldest child, eight years, has a decayed spot on one incisor, but no notching; the next, aged six, has perfect teeth. No history of syphilis could be made out in the family.

Dr. TAYLOR asked if the child had suffered from any exhaustive diseases during the development of the teeth, as cholera infantum, etc.?

Dr. STURGIS could not answer; the child was seen accidentally, and appeared perfectly healthy. The mother had lost no children.

Dr. KINNICUTT (by invitation) read the paper of the evening, entitled "*Peliosis Rheumatica*" (see p. 193, Archives of Dermatology.—ED.)

Dr. BULKLEY regretted the confusion necessarily arising from the use of the term *peliosis rheumatica*, as applied to this affection, which was certainly a form of *purpura*, and not, as Tilbury Fox says, only erythema complicated by haemorrhage. Dr. B. had repeatedly met with the disease, both in Hebra's wards and in

this country, and recalled four cases seen within certainly two years. Three of these were in males, aged respectively about 40, 35 and 11 years, and one woman of about 34. They all occurred among the poorer classes, but in no instance was there any sanitary or dietary error evident, none of the patients lived in cellars, and all could command moderately good food. In three of the patients the rheumatism was a prominent feature, causing much suffering, and in one of these three there was also a decidedly haemorrhagic tendency, the gums being very puffy and bleeding readily. In the man aged 40, the rheumatism had lasted three weeks when first seen; the purpura had appeared shortly after the joint pains. The ankles, knees and hands were swollen and painful, but no eruption appeared, except on the legs. The skin lesion was clearly haemorrhagic in character, the spots small; they passed through the ordinary changes of purpura. In the woman, aged about 34, the elbows were severely affected, also the wrists and knees; the eruption was also profuse around the elbows and on the forearms, as well as at the knees, and there were several crops of the petechiae, which were generally small and circular. The case of the boy, aged 11, was seen in consultation with Dr. Munde, and was published by him in the Am. Jour. Obstet., August, 1874. Both legs below the knee, and the posterior surface of both thighs, the nates and both forearms were the seat of the purpuric eruption. The rheumatic complication was slight, consisting of muscular swellings and pains.

Dr. KEYES narrated a case of purpura in a girl aged 16, who had had repeated epistaxis and menorrhagia, where the eruption, which was confined to the lower limbs, with a little on the body, was ushered in with a chill. There were no articular pains; the spots were slightly elevated and not very livid. Was this peliosis rheumatica?

Dr. KINNICUTT said that the rheumatic pains were necessary in order to constitute the disease peliosis rheumatica.

Dr. TAYLOR had seen two cases of the disease. He recalled the fact that in erythema nodosum the rheumatic symptoms may also be very well marked, as emphasized by Troussseau.

Dr. BULKLEY said that in one of his cases the hæmorrhagic tendency, as well as the rheumatic tendency, were very well marked. The man suffered greatly from the arthritic pain. He had not seen this mentioned by any writer.

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*Fifty-ninth Regular Meeting, October 6, 1874.*

Dr. STURGIS related the history and presented a water color drawing of a child 13 years old, with *interstitial keratitis*, in whom the permanent teeth were distinctly notched and well represented in the drawing, corresponding to the appearances delineated by Hutchinson. The eye presented a peculiar salmon-colored alteration in the centre of the cornea, with a considerable amount of peripheral vascularization. This color is rarely found in these cases, according to Hutchinson.

Dr. KEYES inquired if the mother had had miscarriages since the birth of this child.

Dr. STURGIS answered that the mother showed traces of probable ulcerating syphilide.

Dr. FOSTER then read the paper of the evening, announced as "*Impetigo contagiosa*," a clinical report. The term "*impetigo contagiosa*" was given to them for want of a better one, although it was doubtful if they could be properly so called. (The paper was since published under the title, "*Herpes contagiosus varioliformis*," in the Archives of Dermatology, January, 1875, p. 97.—ED.)

Dr. BRONSON was not acquainted with the *impetigo contagiosa* clinically, and was inclined to regard it as only a species of impetiginous eczema, depending upon some primary condition, as filth or pediculi capitis. He mentioned a case which he had thus named, which originated from a burn on the lower lip.

Dr. BULKLEY said that he had repeatedly met with the disease contagious impetigo in this country, corresponding exactly to that shown him by Tilbury Fox in London. He had seen two of Dr. Foster's cases with him, and had called them by that name,

although presenting certain features unlike the other cases he had seen, and different from those laid down by Dr. Fox, as Dr. Foster had noted in the paper. But he considered that these differences might readily be accounted for by the habits or surroundings of the patients, while we might readily expect that the disease can present features measurably unlike those observed in England and yet be the same affection. The superficial character of the eruption, its puro-vesicular nature, its crusts, and its evident contagiousness in this group of cases, were to him sufficient elements to give the name *impetigo contagiosa*, and to cause him to consider the disease identical with that described by Dr. Tilbury Fox.

Dr. PIFFARD remarked that certain cases of impetigious eczema resembled the disease under consideration, as Dr. Bronson had said, but the true *impetigo contagiosa* was a different affair, and could never be thus caused. He still regarded it as produced by a vegetable parasite. An old specimen of a crust, put up two years ago, he recently found to be filled with mycelium.

Dr. KEYES inquired as to the fluid in which it was preserved.

Dr. PIFFARD answered soda and glycerine.

Dr. KEYES—Was the cell still hermetically sealed? Ans. Yes.

Dr. BRONSON said that in a specimen of cartilage put up in damar-lac he had found a fungus one year afterward, and did not think that the mere fact of finding the mycelium in the crusts by Dr. Piffard, was evidence of any weight.

Dr. TAYLOR said that it was difficult to conclude very positively from a verbal description of cases as to their exact nature. He was inclined to differ from Drs. Foster and Bulkley as to the diagnosis of these cases. He thought that the changes which the vesicles of contagious impetigo undergo are very characteristic, and that the clinical features of the disease did not differ in England and in this country. Several years ago he had traced the vesicles from their formation to the end, and had reported four cases in full, and seen many others. With him the disease corresponded very closely to the description of *impetigo contagiosa* by Fox.

He thought that successful inoculation was not conclusive of its contagious nature, inasmuch as the particles of impetiginous eczema could excite an inflammation if inoculated. The application of iodine to the skin coagulates the tissues, and thus arrests the vesicle, but it does not follow that it destroys any germs. He thought that the vesicles in these cases behaved differently from those of impetigo contagiosa. In the latter the vesicle usually flattens, and the contents and covering dry into a crust, whereas in Dr. Foster's cases they frequently ruptured. He could not call these cases contagious impetigo, although doubtful as to their real nature.

Dr. FOSTER explained that the diagnosis was not exactly clear to his own mind, but was in part arrived at by exclusion.

Dr. TAYLOR said that an important feature in impetigo contagiosa was the febrile reaction, which, though slight, was still insisted on by Dr. Tilbury Fox, whereas Dr. Foster stated that there was none whatever in his cases. Three thousand miles could not make that difference in the disease.

Dr. FOSTER did not regard the disease as contagious because of any proof afforded by the inoculation, but from the clinical history as given. There may be differences in diseases here and in England. He would not assert positively that there was no febrile reaction; there may have been in some of the cases.

Dr. TAYLOR asked if the apparent contagiousness could not be the result of some miasmatic influence?

Dr. FOSTER thought not; the histories pointed to contagion.

Dr. PIFFARD believed that clinical differences could occur in different countries, and that while Dr. Tilbury Fox had described impetigo contagiosa as he had seen it, we were not bound to adhere entirely to his description.

Dr. FOSTER denied the power of iodine in arresting the development of a pock by the coagulation of tissue.

Dr. BULKLEY still held to the diagnosis impetigo contagiosa; the cases were certainly not eczema, varicella or vaccinia.

*Sixtieth Regular Meeting, November 3, 1874.*

Dr. KEYES showed a child which had been sent to him as probably a case of *inherited bone syphilis*. The affection was of two or three weeks' standing; the parents had not been ascertained to be syphilitic. The child's age was two years and four months, and it was plump at its birth. In July, 1873, a number of "boils" appeared about the head; the temporary teeth were notched. Three weeks ago a lump appeared over the junction of the diaphysis and the epiphysis of the right radius. After about two weeks fluctuation became evident, but the swelling was not very tender. It was opened, and the walls collapsed. One of the boils, situated over the temple, had left a depressed scar, with a vacuity. There was still some redness and swelling about the wrist, but no tenderness. The sinus was furnishing a thin discharge. There were no lesions elsewhere. The child had been vaccinated at the age of eight or nine months, and the vaccination had run a normal course.

Dr. TAYLOR did not consider the case as unmistakably syphilitic.

Dr. STURGIS had seen the deciduous teeth notched, both in syphilitic and non-syphilitic children. He inquired if they could not be present in tubercular and other dyscrasiae. He thought it very likely that, in this case, the lesions were not due to syphilis.

Dr. KEYES had seen both the deciduous and the permanent teeth notched in non-syphilitic subjects.

Dr. OTIS had ceased to attach much importance to notching of the teeth.

Dr. FOSTER thought a distinction should be drawn between mere notching on the one hand, and on the other hand, the incurvated free edge and adduction of the upper central incisors.

Dr. TAYLOR had seen cases like the one shown. He considered that there was probably osteitis at the end of the shaft, with periostitis, of a non-syphilitic nature. He had seen similar lesions follow scarlet fever. Debility appeared to be the cause. The diagnosis could not be made from the lesion alone. He

called attention to Bouchut's recent description of phlegmonous periostitis in young children.

Dr. KEYES also showed a young man, a fisherman, who had been bitten on the left thumb by a shark, some time in June last. The wound, which made two sides of a triangle, raising the included flap, soon closed, but was followed by a vivid-looking lump, which burst and gave issue to a dark fluid. Ulceration then occurred, and there was now an open surface as large as a dollar, oblong in shape, elevated, with the edges curled up, of a livid look, and very painful at times. There had been red lines running up the forearm, with enlargement of the epitrochlear gland and of various glands elsewhere. The ulcer was movable. He considered the case as probably one of chancre. There were plaque-like patches in the throat. The patient's general condition was perfectly good.

Dr. OTIS would be inclined, from the appearance of the lesion, to diagnosticate syphilis, but failure of the eruption would seem to conflict with this view. He would use mercury tentatively.

Dr. PIFFARD was in doubt as to the nature of the lesion.

Dr. KEYES, in answer to Dr. Otis, stated that the secretion had not been examined microscopically. He considered the lesion a hard chancre.

Dr. TAYLOR had seen simple ulcers of traumatic origin, simulate syphilis. Induration would not be apt to be well defined in chancres on the hand, and hence would not be of much value in this case. Simple ulcers might run a course of this sort without the existence of any cachexia

Dr. KEYES, in answer to Dr. Sturgis, said that the ulcer appeared about the last of July. (The ulcer improved rapidly under the use of the bi-chloride of mercury,  $\frac{1}{8}$  to  $\frac{1}{2}$  grain doses, and is now completely well. No local treatment was employed. Ed.)

Dr. OTIS showed a *dilating urethrotome* which he had contrived.

Dr. SATTERLEE read a paper on the abortive treatment of erysipelas. (Published in the New York Medical Journal December, 1874. Ed.)

In the discussion of this paper, Dr. Piffard referred to recent investigations of the histology of erysipelas, showing proliferation of fusiform connective-tissue corpuscles as an element, and he also reminded the members that the treatment by large doses of quinine had already been published in France.

Dr. WEISSE remarked that bacteria, or similar germs, were always present in the blood in erysipelatous diseases. These germs seemed to enter the general circulation through the lymphatics leading from the inflamed tissue.

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*Sixty-first Regular Meeting, December 8, 1874.*

Dr. PIFFARD introduced the subject of the evening, "A new clinical classification of diseases of the skin." (Published elsewhere in this issue, p. 216. Ed.)

In discussion of the classification of Dr. Piffard,

Dr. FOX thought it in many respects an improvement on that of the French, but it had the defect of being based in part upon the *causes* of disease and in part upon clinical features.

Dr. FOSTER thought that Dr. Piffard had made an advance in adopting a clinical basis, as he regarded this the most useful form of classification. He was pleased with the method followed with the syphilides, that of Bazin, and spoke of the evil of connecting the names of ordinary eruptions with those of syphilis, as syphilitic psoriasis.

Dr. BULKLEY thought that the whole matter of nomenclature and classification of skin diseases had been very much mixed up and confused by writers, and had long been desirous of having the society consider the subject, and suggested that a committee be appointed to study the matter, taking Dr. Piffard's classification into consideration, and to endeavor to report at some future meeting a basis on which all could unite in reporting cases, and to advocate its general adoption in this country.

Dr. SATTERLEE desired to have the subject discussed by the society at large as he thought other members might have classifications to offer.

Dr. FOSTER suggested that the committee confer also with Dr. Piffard.

Dr. PIFFARD remarked that he did not present his classification for adoption by the society but wished discussion.

The President appointed as a committee Drs. Bulkley, Fox and Weisse, to consider the matter and to report at a future meeting.

The paper of the evening, by Dr. Sturgis, on "The use of mercury in the late stages of syphilis" was then read by the secretary, in the absence of the writer. (Published in Am. Jour. Med. Sciences, January, 1875.)

Dr. STURGIS advocated earnestly the employment of mercury, even very late in the disease, and regarded the iodide of potassium as the adjuvant and not the principal agent in the treatment. He cited two cases, in one of which a neuritis began to improve, the ophthalmoscopic appearances changing at once for the better, upon the action of mercury, while the iritis had gotten well under iodide alone, but the choroiditis went on to atrophy and the neuritis increased under the same; in the second case, ulceration healed under the mixed treatment, which had resisted the iodide of potassium alone.

His favorite method of using mercury is by inunction to the soles of the feet, directing the patient to wear the same stockings night and day. He also spoke favorably of the external use of the oleate of mercury, 20 pr. ct. solution, with or without morphia, half a drachm to a drachm being rubbed in at night, as being cleaner and more rapidly absorbed. The bi-chloride internally he thought objectionable, because its toxic effect was produced before its therapeutic, while the hypodermic method he disliked for many reasons. He thought that mercury so far from producing a depressant effect acted as a tonic when it was required.

As to the continuance of the treatment, Dr. Sturgis thought that it should be continued only till the disappearance of the symptoms, or for a month after, contrary to the opinion of many, and that a tonic course afterward would best protect the patient from a relapse.

In discussion Dr. KEYES said that he had always believed in the use of mercury in the early and late stages of syphilis, and that it cured if any thing could. He believed, however, in combining the mercury and iodide of potassium.

Dr. BULKLEY mentioned the case of a gentleman, aged forty-six, who had choroiditis with atrophy very late in syphilis, in which the mixed treatment of proto-iodide of mercury, one-half grain morning and night, with from eight to fifteen grains of iodide of potassium three times daily, had produced very great improvement. The patient gave no syphilitic history, he being a remarkably observant and intelligent gentleman, except a scaly eruption on one hand nearly two years previously, which rapidly vanished on the same mixed treatment. Dr. Sturgis had repeatedly examined the eye ophthalmoscopically, and had watched the patient with him. Here is a suspicion of a primary sore about twenty years previously.

Dr. SHERWELL (by invitation) said that he had used the oleate of mercury largely, and found it to act very pleasantly in palmar syphilides, the patient simply covering the hands with the oil, rubbing it in slightly, and drawing on gloves.

Dr. BULKLEY asked if the patient took the iodide of potassium at the same time.

Dr. SHERWELL replied that he had been using the iodide with but little improvement, but great change was apparent on the use of the oleate.

Dr. WEISSE concurred fully with Dr. Sturgis' views as to the value of mercury late in syphilis; his favorite plan is inunction, with the iodide of potassium by the mouth.

Dr. PIFFARD said that he always gives mercury in every stage, generally alone, never using iodide of potassium except where brain lesions threaten; the latter relieves, but does not cure, and he further believes that it rather encourages relapses.

Dr. FOSTER agreed with Dr. Piffard fully, but he always uses the corrosive chloride alone, never giving iodide of potassium in syphilis except for osteoscopic pains or for brain troubles.

Dr. PIFFARD said that he made frequent use of sulphur, internally in syphilis, quoting Andral in an assertion that "sulphur neutralizes the toxic effect of mercury."

Dr. TAYLOR believed in mercury in the primary or secondary manifestations, but advocated a mixed treatment in older cases. He thinks the opprobrium cast on iodide of potassium was not well founded, and he further criticised Dr. Foster as to the value of the bi-chloride, as he believed that it irritated the stomach, produced colic, furred tongue and diarrhoea. He also supported the sub-cutaneous use of mercury in certain cases. He was surprised at Dr. Sturgis advising the 20 pr. ct. solution of oleate of mercury, as he thought the 10 pr. ct. should even be used with caution; he had found the latter to blister when applied to adenopathies.

Dr. SHERWELL said that he had made use of the 6 per ct. solution.

Dr. SATTERLEE agreed with Dr. Foster as to the value of the bi-chloride of mercury in the compound tincture of cinchona, always after meals.

Dr. WEISSE used the bi-chloride, and recalled but one case where it was not tolerated; there  $\frac{1}{8}$  grain was used.

Dr. FOSTER begins with  $\frac{1}{2}$  and goes to  $\frac{1}{8}$ . This was the standard treatment in the New York Hospital.

Dr. BULKLEY gave mercury and iodide of potassium, always combined with iron, nux vomica, and cinchona, in almost every stage of syphilis. His favorite methods are Ricord's, of the proto-iodide,  $\frac{1}{2}$  grain doses, morning and night, and iodide of potassium with the iron, nux vomica and cinchona, after meals, or the mixture containing  $\frac{1}{32}$  grain of the bi-chloride in the same mixture with from 8 to 15 grains of iodide of potassium thrice daily, after eating.

Dr. FOX asked if any one had used the bi-cyanide of mercury, much recommended in England. It produced no gastric symptoms.

Dr. KEYES had employed it, but with no striking result. He uses the bi-chloride in tincture of bark.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### ANATOMY, PHYSIOLOGY AND PATHOLOGY.

A. R. ROBINSON, M. D.

1. **Ebstein, W.** — On a pathological anatomical appearance of the cervical sympathetic found in a case of unilateral hyperhydrosis. (*Ueber einen pathologisch anatomischen Befund am Halssympathicus bei halbseitigem Schweiß.*) Archiv für Path. Anat. und Physiologie und Klin. Med., 22 Bd., 3 Heft., Jan. 20, 1875.

2. **Greve.** — Black pigmentation of the skin in a new-born child. (*Schwarze pigmentirung der Haut bei einem neugebornnen Kinde.*) Allg. Med. Central Ztg., 37, 1874.

3. **Jobert.** — The human hairs considered as tactile agents. (*Des poils considérés comme agents tactiles chez l'homme.*) Gaz Med. de Paris, Feb. 6, 1875.

4. **Lang, Edward.** — On the nature of the so-called giant cells in lupus. (*Ueber die Bedeutung der sogennanten Riesenzellen im Lupus.*) Vierteljahr. für Derm. u. Syph., 1874, II und III Heft.

5. **Neusell.** — Rare case of spotted child. (*Seltener Fall eines scheckigen Kindes.*) Allg. Med. Central. Ztg., 22, 1874.

6. **Schlitz.** — Pathological anatomy of Elephantiasis. (*Pathologische Anatomie der Elephantiasis.*) Archiv der Heilkunde, 2, 1874.

EBSTEIN (1) describes the pathological changes observed in a case of unilateral hyperhydrosis. The sweating showed itself on the left side of the head, body and upper extremity. Hyperæmia of the parts was not observed during the sweating. Pupil of left eye was normal. Microscopically, the nerve cells of the cervical sympathetic were alike in both sides, being strongly pigmented, some being quite black colored. Sometimes dark granules were observed in the cells in such quantity as to conceal the nucleus. On the left side, especially in the lower cervical ganglion, round

and streaked places, the size of a grain of sand, of a brown dark color, were to be seen, which, under the microscope, appeared as cavities lined with endothelium and filled with blood corpuscles. These could be frequently followed in the long axis of enlarged blood vessels. They then represented dilatations of the vessel which alternated with constrictions. The wall of such a cavity was rather thick, and contained large numbers of spindle-shaped nuclei, which were especially numerous in the peripheral layers. In the foregoing changes in the calibre of the blood vessels, producing compression of the ganglion cells, he, arguing from analogy in some other diseases, finds the cause of the hyper-hydrosis.

JOBERT (3) has studied the supply of nerves to the hair follicle in different parts of the face. He found the greatest number of terminal nervous filaments to the follicles at the free border of the lids. Here, whilst some of the nerves terminate at the most superficial part of the skin, the greater number are distributed to the follicles of the eyelashes. His description of their mode of termination is as follows: "Bundles of dark-bordered fibres pass to that part of the follicle beneath the sebaceous gland. A single bundle, composed of three or four tubes coming from different directions, proceeds toward a particular follicle. Some tubes penetrate directly, but the greater number of the fibres creep along the external membrane of the follicle, surround it, making a real necklace; the directions of the tubes then change, they become vertical, mount parallel, in the thick part of the follicle, and after proceeding a certain distance, become invisible. With osmic acid one sees distinctly that the nerves lose their dark border, and that they penetrate as far as the vitreous membrane, upon which they creep. After that they have lost their medullary sheath, they show in their course small fusiform enlargements, become so tenuous that they cease, so to speak, to be measurable; the course of the fibres is then rectilinear or sinuous and the small fibres terminate in a small hyaline enlargement."

Prof. LANG (4) considers that the so-called giant cells found in lupus are only retrograded metamorphosed cell masses, and that they arise in the following manner: The cells in the centre of a lupus mass undergo irregularity in their tissue change in proportion as the mass increases in size; and in this manner they lose their physiological function, though they may still retain their form for a considerable length of time; afterward they coalesce,

lose their mark of demarcation, the nucleus, as the more stable structure, alone remaining recognizable in the faint brown mass. This happens, according to Lang, not only in the lupus masses lying in the connective or other tissues, but also in hollow structures such as blood vessels or lymphatics, closure of the vessel being produced by pressure from the cell collection surrounding it; and this leading to a cell mass collection within the vessel, the cells of which undergo the same changes already described as taking place in the masses outside the vessels.

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## INFAMMATIONS; ACUTE AND CONTAGIOUS.

FRANK P. FOSTER, M. D.

1. **Adler, H.**—On the affections of the eye which accompany and follow small-pox. (*Die während und nach der Variola auftretenden Augenkrankheiten.*) Vierteljahresschr. f. Dermat. u. Syph., I Jahrg., 2 and 3 Heft., p. 175.

2.—The vaccination law of the German empire. (*Impfgesetz für das deutsche reich.*) Vierteljahresschr. f. Dermat. u. Syph., I Jahrg., 2 and 3 Heft., p. 387.

3. **Finamore.**—Statistics of a small-pox epidemic at Gessopalena, 1871-72. (*Dati statistici intorno ad un' epidemia di vajuolo in Gessopalena, 1871-72.*) Giorn. Ital. delle Mallattie Veneree e della Pelle, June, 1874, p. 143.

4. **Brouardel, P.**—Lesions of the heart and aorta in small-pox. (*Etudes sur la variole; lésions vasculaires [cœur et aorte].*) Arch. gén. de Méd., Dec., 1874, p. 641.

BROUARDEL's (4) investigations go to show the existence of inflammatory lesions of the pericardium, the endocardium, and the lining membrane of the aorta, as constituting well-defined manifestations of the variolous poison. They are in all respects confirmatory of the researches of Hayem and of Desnos and Huchard.

5. **Roth, F.**—On rötheln. (*Ueber Rubeola*) Deutsch. Archiv f. klin. Med., 14ten Bd., 5 u. 6tes (doppel.) Heft, p. 532.

ROTH (5) describes an epidemic of rötheln which he observed at Erlangen in the summer of 1873. The article opens with a summary of the views held by various authors since the time of

Heim, as to the nature of the disease and its relations with scarlet fever and measles. The diagnostic points by which these affections may be distinguished from rötheln are briefly considered.

6. **Coats, J.**—Acute interstitial inflammation of the kidneys in scarlet fever, fatal on the tenth day. *Brit. Med. Jour.*, Sept. 26, 1874, p. 400.

7. **Allbutt, T. C.**—On the modes of death in the earlier days of scarlet fever. *Lancet*, Nov. 7, 1874, p. 652.

8. **Taylor, J.**—The wet sheet in scarlatina. *Lancet*, Nov. 14, 1874, p. 692.

COATS (6) relates the case of a man 20 years of age, who came under the observation of Dr. McLaren on the fifth day after the commencement of scarlet fever. Four days after his admission to the Glasgow Royal Infirmary, the eruption was noted as still present on the abdomen. He died the next day, having in the meantime been exceedingly restless, delirious at night, and only half conscious. Both kidneys were found enlarged, the two together weighing 22 ounces. They had the appearance of the large white kidney. The microscopical characters were unequivocally those of acute interstitial nephritis, an affection of which the existence has been doubted.

ALLBUTT's article (7) is a summary of one or two of his regular lectures, and what he says is more especially founded on his observation of the epidemic of the past two years in Leeds—an epidemic which, as Allbutt thinks, has been distinguished by a large number of rapidly fatal cases. He believes that scarlet fever threatens life within the first two or three days, in the four following modes: (1) by *hyperpyrexia*, (2) by *specific poisoning*, (3) by *malignancy*, and (4) by *syncope* or *asthenia*. Death may sometimes be owing to two or more of these conditions acting conjointly. The hyperpyrexia of scarlet fever does not differ materially from that of various other diseases. Allbutt gives warning against a too implicit trust in the peculiarly pungent heat of the surface which is so commonly spoken of as characteristic of scarlatinal hyperpyrexia. He has even seen an algid reaction. The hyperpyretic condition may escape observation in its development, unless the thermometer is used. By the provisional term, "specific poisoning," Allbutt designates those cases in which, while the fever may be less than commonly occurs, the outset of the disease is attended with marked disturbances of the

nervous system. Although not absolutely hopeless, this condition is graver than that of hyperpyrexia. There is no rational indication for treatment, and no known empirical method of management has been shown to be of benefit. This phase of the disease seems limited to the first few days, although the subsequent outbreak of a favorable rash does not always prevent death from this cause. It does not seem to pertain particularly to malignant cases. Malignant cases begin with typhoid symptoms, which, in Allbutt's opinion, originate independently of uraemia. They are less rapidly fatal than the hyperpyretic cases or those of nervous poisoning, and sometimes end in recovery. In the asthenic form, which is rarely seen, it is the circulatory rather than the nervous system which seems to be oppressed; the pulse becomes soft and rapid, the breathing shallow and frequent, and the patient tosses about like a woman who has been flooding. Individual symptoms are not very severe, but yet death is readily seen to be imminent, and the patient succumbs at once, without the slightest attempt to rally. By an error in the use of words, towards the close of the article, Dr. Allbutt speaks of the "duty of curing the former [direct poisoning], whatever you may be able to do with the latter [hyperpyrexia]," which is evidently the very reverse of what he meant to say.

9. **Satterlee, F. L.**—Erysipelas; its etiology, pathology, and abortive treatment by quinine and opium. *N. Y. Med. Jour.*, Dec., 1874, p. 579.

10. **Bohn.**—Vaccinal erysipelas and its bearing upon the theory of erysipelas. (*Das Impferysipel und seine Bedeutung für die Erysipelaslehre.*) *Jahrb. f. Kinderheilk.*, N. F., VIII Jahrg., 1 Heft., p. 1.

11. **Luhe.**—A contribution to the etiology of erysipelas. (*Zur Aetiologie der Rose.*) *Deutsch. Archiv f. klin. Med.*, 15ten Bd., 1 Heft., p. 99.

BOHN (10) analyzes several hundred cases of the erysipeloid complication of vaccinia, and treats of the subject, more especially in its points of resemblance to and difference from ordinary erysipelas, exhaustively. The article will scarcely bear condensation.

LUHE (11) gives three groups of cases of erysipelas. The first case in each group was manifestly of traumatic origin, but it was a question whether the others were due to contagion, or whether all of the cases arose from some circumscribed source of infection.

## HYPERTROPHIES, ATROPHIES AND NEW FORMATIONS.

E. WIGGLESWORTH, JR., M. D.

1. **Davies, D. A.** — A case of acute general hypertrophy of the papillary layer of the skin. *Lancet*, Sept. 26, 1874.
2. **Depres, A.** — Hétéropie pileuse cutanée congenitale. *Gaz. hebd.*, 1874, No. 16.
3. **Broca.** — Nutritive disturbances of the hair and nails. *Gaz. des Hôp.*, 42, 1874. Wimmer. Schmidt's *Jahrb.* Bd. 164. No. 12, 1874.
4. **Lagrange, A.** — Contribution to the study of scleroderma, arthritic complications and osseous atrophy. *Contribution à l'étude de la sclérodermie, etc.* 1874. Paris.
5. **Fox, T.** — *Morphœa alba.* *Lancet*, Oct. 10, 1874.
6. **Stowers, J. H.** — Case of *morphœa alba*. *Brit. Med. J.*, Oct. 24, 1874.
7. **Brett, J.** — Elephantiasis of right leg. *Guy's Hosp. Reports.* *Lancet*, Oct. 24, 1874.
8. Elephantiasis, ligature of the external iliac in. *Med. Times and Gazette*, July 4, 1874.
9. **Lloyd.** — Elephantiasis scroti. *Lancet*, Aug. 29, 1874.
10. **Lloyd, C.** — Cases of Elephantiasis scroti; removal. *Dublin J. of Med. Science*, Sept., 1874.
11. **Pizzorno.** — Elephantiasis of the scrotum; removal. *Di una elefantiasi dello scroto, etc.* *Lo Sperimentale.* Agosto, Fasc. Sc., 8.
12. **Paul.** — Elephantiasis of the prepuce, etc. *Ann. de Dermatol. et de la syph.* T. v. No. 1.
13. **Voillemier.** — Elephantiasis of the penis and scrotum. *Ann. de Derm. et de la syph.* Tome v. No. 1.
14. **Beck, Marcus.** — Fibrous tumor of the penis. *Trans. of the Pathological Society*, vol. xxiv, p. 153.
15. **Gay, John.** — Papilloma on the penis. *Trans. of the Patholog. Soc.*, vol. xxiv, p. 154.

DAVIES (1) reports the case of a man, aged 55, in whom itching, sleeplessness, etc., were followed by hypertrophy of the skin

of the trunk, the nipples one and one-half inches long, condylomata of anus, phymosis, congested hypertrophied palpebral conjunctivæ, florid, spongy gums, and a villous condition of the tongue. Neither the treatment employed nor its final results are stated.

DEPRES (2) reports and depicts the case of a new-born female child, covered almost universally with long, dark hair, the skin pigmented and in places greatly hypertrophied.

LAGRANGE (4), in his graduation thesis, gives the history of scleroderma, and four observations of the disease accompanied by atrophy. Thiréal, in 1845, called attention to the affection, but did not name it. Two years later it entered the nosological catalogue. Horteloup, in 1865, reported 27 cases. Coliez, in 1874, 43 cases. Single cases are reported by Rasmussen, Verneuil, Lasègue, Grisolle, Forget, Gintrac, Rilliet et Barthez, Gilette, Arning, Förster, Auspitz, etc. Thus far, alterations of the skin and ankyloses of the small articulations had alone been described. But in 1871, Dr. Ball reported to the Society of Biology a case in which occurred atrophy of the bones of the fingers, both as to length and thickness; and in the same year a similar one was reported by Dufour. In 1873, Lépine reported a third case, accompanied by nearly universal melanoderma. The fourth observation was by Budin and Lagrange of a case observed four years previously, in 1869, by Hallopeau. In this case an autopsy and microscopical examinations were made. An autopsy has been made in only five other cases, according to Rasmussen, viz., in those of Förster, Köhler, Gintrac, Auspitz and Arning. Microscopical examinations have been made by Hebra, Neumann, Rossbach and Fieber. Lagrange deduces from his four observations that the disease is a secondary trophoneurosis from the primary chronic inflammation of the skin and subcutaneous cellular tissue.

VOILLEMIER (13)—*Elephantiasis of the penis and scrotum.*—A joiner, who had never quitted France, noticed at the age of 22 years, and every spring and autumn subsequently, swelling, redness, heat, itching and a papular eruption of the genitals, with some general fever. The attacks lasted a fortnight. The swelling did not diminish after the attack, and the accession of bulk semi-annually resulted, after seven years, in so large a tumor that he applied for operation. He was thin, dejected, and confessed being a confirmed onanist. The tumor involved the scrotum, but still more the penis, was cylindroid, and somewhat pedunculate at

the pubes. Its longitudinal perimeter from pubes to anus was about three and one-half feet; the circumference of the peduncle about 13 inches, and that or its lowest third, the largest part, about 20 inches. It was red and œdematous, the sensibility obtuse, the scrotum brown, the skin of the pubes dragged down. The meatus was on one side, and the whole finger inserted could not reach the glans. Erotic thoughts caused swelling of the penis within the tumor and emissions. The mass was removed and allowed to drain off until the next day, when it weighed 3 lbs, 3 oz., 1 dr., 43.2 gr. It was composed of a grayish, fibrous tissue, elastic and very tenacious. The fluid obtained by pressure was not coagulated by heat. The wound healed in six weeks. The patient returned five months later with a cold abscess of the right pectoralis major, a chancre at the base of the glans, plaques muqueuses, etc. He again left after three months, and when seen, a year from this time, showed no return of the tumor. Such operations are often followed by gangrene. Voillemier attributes his marked success to the fact that he avoided useless dissection, denuded the organs as little as possible, and made liberal allowance for the disappearance, from the tissues remaining after the operation, of previously existing engorgement. An aperture should also, he holds, always be left for drainage, to obviate the subsequent occurrence of abscesses. Voillemier considers that relapses after operations rarely, if ever, occur. Patients remaining subject to the same conditions of life and climate may, for this reason, be subsequently affected as they were at first, but even here, usually in a different part of the body. A favorable condition for a relapse was when the patient returned with syphilis, but even here none occurred.

To this case is appended another by PAUL (12). Schmidt, moulder,  $\text{\AA}$ Et. 25, married a year and a half, noticed, a year since, a swelling of the glans penis. This lasted a week, and occurred monthly for six months, the swellings disappearing in the interim. Six months since the prepuce and glans both swelled, and the swelling has not disappeared. Penis about four and three-fourths inches in length, pear-shaped, the skin mamillated and wrinkled, reddish, much thickened and elastic. Micturition easy, jet small, urethritis, painful erections, but no emission. The hypertrophied tissues were removed, the wound cicatrized in about a month, and the patient, seen two years later, had had no return of the malady.

16. Michel, M.—Fibroma molluscum, case of, with remarks Am. Jour. of the Med. Science, Jan., 1875, p. 24.
17. Dubrueil.—Lipomata. Bull. dé Thér. lxxxv, p. 521, Dec. 15, 1873.
18. Hasse.—Lipomata. Tagebl. d. Naturf.—Versamml. zu Leipzig, 1872. Schmidt's Jahrbuch, No. 5, 1874.
19. Geber.—A rare form of nævus. *Ueber eine seltene Form von Nævus der Autoren.* Viertelj. für Derm. und Syph., 1874, Heft. I.
20. Jaffe, Th.—Vascular sarcoma. *Zur Kenntniss der gefäßreichen Sarcome.* Arch. f. klin. Chir., 1874. xvii, 91-107.
21. Duhring, L. A.—Angioma with sarcomatous degeneration. Path. Soc. of Phil'a. Phil'a Med. Times, Aug. 8, 1874.
22. Trelat.—Painful Angiomata. *Angiomata douloureux.* Gaz. Méd., Sept. 26, 1874.
23. Demange.—Mycosis fongoide ou lymphadénie cutanée. Annales de Dermat. et de la Syph. Tome V. No. 2.
24. Demange, E.—Lymphadenoma. *Etude sur la lymphadenie.* Paris, 1874, 8°, 86 pp.
25. Wilson, Erasmus.—Lymphadenoma of the skin. Med. Times and Gazette, Sept. 5, 1874.
26. Duhring, L. A.—Lupus vulgaris. Phil. Med. Times, July 18, 1874.
27. Friedlander.—Untersuchungen über Lupus. Arch. f. Path. Anat. u. Physiol. u. f. Klin. Med. Bd. lx Heft. 1, 1874.
28. Lang.—Lupus und carcinom. Viertelj. f. Dermat. und Syph. I. Jahrgang, 2 und 3 Heft., 1874.
29. Gaskoin, Geo.—On leprosy and lupus as signs of innutrition. Med. Times and Gazette, London, Sept. 5, 1874.
30. Bull and Hansen.—Eye affections in leprosy. *Lepröse Augenerkrankungen.* Centr. bl. f. d. Med. Wiss. Ibidem.
31. Carter.—Report on leprosy and leper asylums in Norway. London, 1874. Edinburgh Med. Jour., Sept., 1874.
32. Danielssen.—Leprosy in the Lungegaards hospital. Norsk. Mag. f. Læg., June, 1874.
33. Dougall.—Leprosy. Med. Times and Gaz., June 20, 1874.
34. Hillairet.—Eléphantiasis des Grecs.—Analyse du Sang. Ann de Dermat. et de la Syph., T. V., No. 3.

35. **Renault.** — Anæsthetic leprosy, becoming subsequently tuberculous. *Observation de Lèpre Anesthésique*, etc. L'Union Méd., 29 Janvier, 1874.

36. **Lisboa, J. C.** — Papers on Leprosy. Bombay, 1874; Edinburgh Med. Jour., Sept., 1874.

37. **Bryant.** — Cases of Epithelial Cancer. Med. Times and Gaz., July 4, 1874.

38. **Obalinski.** — Two cases of epithelioma cured by condu rango. *Heilung zweier Fälle von flachem Epithelialkrebs*, etc Centralbl. f. Chir., No. 12, 1874.

39. **Thiry.** — Epithelioma of the penis; operation; recovery. Presse Méd. Belge, No. 50.

40. **Volkmann, R.** — Tar and soot cancer. *Ueber Theer und Russkrebs*. Berl. Klin. Wchsft., March 4, 1874.

41. **Wyman, Hal. C.** — Malignant disease of penis, following phagedenic ulcer. Phil. Med. and Surg. Reporter, June 7, 1873.

42. **Harvey, R. J.** — Lymphosarcoma of the face. Dublin Jour. Med. Sci., Sept., 1874.

43. **Nystrom.** — Multiple melanotic tumors. Centbl. f. d. Med. Wissenschaft., July 4, 1874.

44. **Tholen, Fr.** — Malignant lymphosarcoma treated by arsenic. Inaugural dissertation, 1874; Wiener Med. Wochenschrift, No. 28, 1874.

45. **Zahn.** — Alveolar epitheloid sarcoma of the lymphatics of the neck. Arch. d. Heilk., Jahrg., XV., Heft. 2, 1874.

46. **Kuster.** — New formations at the navel of adults, and their operative treatment. Arch. f. Klin. Chir. Bd. XVI., Heft. 1, p. 234, 1874.

47. **Cameron.** — The dispersion of tumors by puncture. Practitioner, Sept., 1874.

MICHEL (16) reports the case of a healthy sailor,  $\text{\AA}$ Et. 28, whose whole body became covered, without constitutional irritation, by small tumors, painful only on pressure. One of these became fungous. The others, 40 in number, were round or oval, hard, almost fibroid, of the size of a small marble, and fixed in and projecting from the derma. The skin over them was smooth and at first normal in color, becoming later dark brown; sometimes the growths ulcerated, but as the rule dried up and desquamated. The tumors were mostly sessile, sometimes, however, pedunculate,

and one, on the neck, was pendulous, elongated and pointed like the tail of a mouse. When the tumors disappeared, their sites were marked by depressions insensible to the prick of a pin. Michel distinguishes this form of fibroma from the sebaceous or "contagious" molluscum, and calls attention to the intimate connection between circumscribed and extended changes in the derma, between, that is, fibroma and dermatolytic and pachydermic alterations. The disappearance of tubera he explains by the speedy degeneration of the individual cells of a plastic product rapidly developed; the permanence of tubera of any magnitude, by a slower increment of tissue, with co-adaptation of its circumfusa, both nervous and vascular, producing a true hypernutrition. The writer concludes by citing the case of Eleanor Fitzgerald, which is also given in the third volume of John Bell's Principles of Surgery, "the most wonderful instance in the world" of true dermatolysis or cutis pendula.

DUBRUEIL (17) applied the Vienna caustic paste to two lipomata. The slough came away in about a week. The tumors were then readily scraped out with a spatula.

HASSE (18) injected, with a hard rubber syringe, pure alcohol, at four different times during a fortnight, into a lipoma upon the shoulder of a lady. At each sitting one or several such injections were made at various points. The reaction following the injection should have passed away before the succeeding sitting is undertaken. The tumor hardened at first, then softened, and, three weeks after the final injection, fluctuated, and being opened, its contents flowed or were squeezed out.

GEBER (19) describes as *Nævus*, an anomaly to which he gives this name, because he understands by it not merely congenital pigment hypertrophies, but such also as develop later from initial appearances so slight as to have been overlooked at birth, or, again, such as in fact do not exist at birth, but must yet be regarded as hereditary, since they are also present in the parents and other members of the family. Mathilda Z., a Silesian of eight years of age, showed no anomaly of the skin until the end of her second year, when the skin around her eyes became discolored, the color rapidly extending and darkening. In her third year a severe catarrhal conjunctivitis supervened, which lasted for many years, causing photophobia. This, united with the fact that in her fourth year the discoloration had spread over her face, neck and backs of hands, and that nodules, rapidly

increasing in size and number, were appearing upon the face, caused her, after three more years, to apply for treatment, with a younger sister in a similar condition. At this time the scalp showed scattered, yellowish-brown, round spots, miliary and pierced by hairs, and some dilated vessels, around the apertures of the follicles. The face showed also other spots, pigmentless, scattered or arranged in rows or even united in bands. On the borders of the deep stains branching dilated vessels were present. The nodules of the face were dark or spotted, hard, painless, movable and seated in the subcutaneous cellular tissue. On the trunk the pigment spots and dilated vessels were less frequent, the colorless spots more abundant, and also upon the lower extremities. Above the elbows to the shoulders only atrophied spots were present, below the elbows, pigment patches also. The pigmented and atrophied spots upon the body reached their highest development where the dark spots and the dilated vessels were most frequent. The subsequent course of the disease showed disappearance of these and an increase of the uncolored marks. The other sister, Laura, was not affected until her fourth year, but the disease presented the same appearances. On the left ala nasi was a broad, flat, hard, slightly raised, dark colored nodule, which only gradually increased in size. The microscope showed that the most important changes were those of the vessels, and especially a bulging of their endothelium, the cells and nuclei being both enlarged, thus enlarging the vessels while diminishing their calibre, some of the smallest capillaries being even completely occluded. Sebaceous glands were everywhere present, their acini often doubled in volume. The pigment around the hair follicles was increased. The retrograde metamorphosis gave the impression of premature cornification. Geber concurs in the opinion of G. Simon and Bärensprung, that the blood is the source of the pigment deposit. He calls attention to the fact of the occurrence of malignant formations in these apparently simple morbid processes. A special investigation with reference to the relation between preliminary inflammatory processes and the production of Sarcoma convinced him of an analogy between the former and the growth of tumor elements, though the nature of the proximate cause which produces, at one time inflammatory products, and at another heterologous elements, cannot as yet be determined.

RENAULT (35) reports a case of anæsthetic leprosy in a Mexican,  $\text{\textcircumflex}t.$  30. In 1861, at the age of 19, he noticed insensibility of under surface of right great toe. In 1865 this spread to the knee. Until 1868 no change, except red spots upon the body and one on each cheek. During this time he had been a soldier under Juarez. In 1869 he came to Paris for treatment. He then showed a tubercle on each cheek, below the orbit, and engorgement of the eyebrows. After apparent amelioration under placebos, he unfortunately was put upon arsenic. The immediate result was a fresh eruption of red spots over the whole body, followed by tubercles upon the ears, face and hands, with rhagades and ulcerations. Reduced in strength by poor nourishment during the siege of Paris, and with almost universal anæsthesia, he entered the hospital in 1872. By 1873 the nose, cheeks, brow and tongue, hands, feet and legs, were covered with tubercles, and several fingers had become distorted. General health pretty good; so, also, appetite and sleep. February, 1873, vomiting after every meal; albuminuria; pain on pressure in left lumbar region, with some swelling of the kidney; pulse 92. Symptoms worse, with frequent epistaxis, stertorous breathing and hoarseness, until March 5, he died. The autopsy showed ulcerated tubercles on the larynx, old pleurisy of right lung, with miliary tubercles, and two small cavities at the apex, with small hard tuberculous masses around them. Also interstitial nephritis, enlargement of the spleen and liver, and heart somewhat fatty. In this case, the first symptom was anæsthesia, with subsequent simultaneous development and progress of tubercles and anæsthesia. This is very rare. Albuminuria is common with leprosy. In this case it occurred very late, and there was never any sign of oedema. Such cases are thought by some to be gravest in their prognosis. There were no nervous phenomena. The temperature during the few days preceding death, after uræmic vomiting had set in, oscillated always between  $95^{\circ}$  and  $97^{\circ}$  Fahr.

KUSTER (46) recognizes as umbilical new formations: I. Of the skin of the navel: Papilloma, dermoid. II. Of the cicatrix of the navel: Papiloma, carcinoma. III. Of the umbilical canal: Sarcoma (?). primary carcinoma (mucous cancer), secondary carcinoma (medullary cancer). The therapy is thorough and complete removal.

## HEMORRHAGES AND NEUROSES.

ARTHUR VAN HARLINGEN, M. D.

1. **Billard, M.**—Case of purpura. *L' Abeille Méd.*, Oct. 19, 1874.
2. **Burness, A. G.**—Hypodermic use of ergot in purpura. *British Med. Jour.*, Oct. 31, 1874.
3. **Lane, Wm. L.**—Hypodermic use of ergot in purpura. *British Med. Jour.*, Sept. 5, 1874.
4. **Munde, Paul F.**—Case of purpura rheumatica. *Am. Jour. Obstetrics*, Aug., 1874.
5. **Richardson, B. W.**—Certain types of disease included under the term purpura hemorrhagica. Read before the London Medical Society. Abstract in *Lancet*, Nov. 21, 1874.
6. **Scheby-Buch.**—Joint troubles in hemorrhagic affections, with some unusual concomitant circumstances. *Deutsches Archiv für Klin. Med.*, XIV Bd., Heft., 5, 6, Dec., 1874.
- 7.—A case of *morbus maculosus Werlhofii*, transmitted from the mother to the child. *Archiv. f. Gyn.* VI, 3. *Am. Jour. Obstet.*, Nov., 1874, p. 521.

RICHARDSON (5) alludes to the fact that one or more diseases are frequently described under a single generic appellation. This particularly applies to the term purpura hemorrhagica. He defines three forms of purpuric disease, each having a distinct pathology, etiology, diagnosis, prognosis and treatment. These he calls (a) aqueous purpura, (b) saline purpura, (c) vascular purpura. Aqueous purpura is so named because in it the water of the blood is in excess, the colloidal and crystalloid parts being relatively decreased; there is no evidence that the actual quantity of fibrin is reduced, but it is distributed through too large a volume of water. This type of purpura has been studied by the synthetical method. The origin of it is to be traced to hereditary causes mainly, but it may arise from mental shock.

In saline purpura the blood is surcharged with some saline soluble substance, by which the plastic colloidal fibrine is held in undue solution. The synthesis of this type is also explained. The disease is not hereditary, but is induced by some error of diet or other cause that increases the solubility of the fibrine.

The author adds that he has seen it induced by excessive use of chloral. Passive exudation from vascular parts is characteristic of this type.

In vascular purpura, the blood is not modified at all, but owing to some defects in the vessels of the minute circulation, they allow the blood to escape if subjected to any blow, strain or pressure. This may be due to paralysis of the vessels, but the author is rather inclined to attribute it to some structural modification of the vessels themselves.

The diagnosis of these three forms is minutely described; the differential characters of the eruption being defined with special care. The author also remarks that these three types may be combined, and concludes his paper by a review of the different modes of treatment required. A special point is made of the best method of arresting the hemorrhage, and Dr. R. dwells on the importance of paying attention to general as well as local measures. For the former, he recommends giving suitable food and mineral acids; for the latter, firm pressure and styptics, although caustic styptics are strongly condemned. The author also points out the value of turpentine in the vascular variety.

**SCHEBY-BUCH** (6) gives the history of three cases; the first, one of purpura hemorrhagica following erysipelas; the second, purpura complicated by urticaria (purpura urticans?); the third, purpura accompanied by acute rheumatism.

1. **Bulkley, L. D.**—The relations of the nervous system to diseases of the skin. *Archives of Electrology and Neurology*, Nov., 1874.

2. **Evans, H. Y.**—Case of pruritus formicans accompanying pregnancy and resulting in abortion. *Am. Jour. Med. Sciences*, Jan., 1875.

3. **Fox, Tilbury.**—Unconscious scratching. *Lond. Lancet* (Am. Practitioner), Nov., 1874, p. 297.

4. **Hamilton, A. McL.**—Chronic vaso-motor hyper-irritation. *New York Medical Journal*, Oct., 1874.

5. “**Lancet Correspondence.**”—Treatment of pruritus vaginæ. *Lancet*, Oct., Nov., 1874, pp. 505, 541, 575, 681, 715, and 750.

6. **Webber, S. G.**—Changes in the skin and its appendages, following lesion of the nervous structures. *Boston Med. and Surg. Journal*, Dec. 17, 1874.

BULKLEY (1) arranges the consideration of his subject under the following heads:

1. Microscopic anatomy of the skin with special reference to its nerve elements.
2. Physiological considerations pointing to nerve origin of certain skin diseases; a, normal; b, experimental.
3. Pathological observations, showing the same, of four kinds a, eruptions directly consequent upon peripheral wounds of nerves; b, eruptions attending lesions of conducting nerves; c, eruptions accompanying brain and spinal disease; d, idiopathic nerve-lesions found, *post-mortem*, in nerves supplying diseased skin.
4. Résumé and deductions.

Under the first head, he gives the results of the most recent investigations as regards the distribution of the ultimate nerve fibres to the integument, and especially the very intimate association of their terminations with the cells of the skin.

The author lays stress upon this association as indicating that the cells are under direct nervous control, possessing self-existent powers, capable under proper nerve stimulation, of absorbing just enough nutriment to maintain their proper relations, while under perverted control they take on morbid action. The very important part taken by the vaso-motor nerves is by no means denied, but simple vaso-motor disturbance alone is insufficient to produce the pathological changes found in many diseases of the skin.

This leads to the second head, under which the author shows that withdrawal of nerve influence by section produces but slight and temporary changes; also, that experimental physiology likewise fails to produce pathological change in the structure of the skin. Close physiological relations are shown to exist between the skin and other organs, evidently the result of neural connection, as in flushing and blanching of the surface and cutaneous perspirations associated with functional derangements of internal organs or mental emotions. The physiological distribution of various diseases, herpes-zoster, etc., upon cutaneous nerve tracts, as well as the phenomena of *réflex* irritation, are alluded to as bearing upon the neuro-pathology of skin diseases.

Under the third head, pathological observation is shown to be rich in demonstration of the direct connection between nerve influence and nutritive changes in the skin. Instances are given

to show that peripheral nerve injury is followed by cutaneous lesions, that lesions of conducting nerves are very constantly followed by the same, and that traumatic, and even idiopathic disease of the spinal cord and brain is not unfrequently accompanied by certain forms of disease of the skin.

Finally, the author recalls the very striking nerve lesions found in herpes-zoster, in cases of traumatic nerve injury, followed by skin disease, and in lepra anæsthetica. The different heads are illustrated by a selection of cases, and the article concludes by a recapitulation of the various points brought forward.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### GENERAL QUESTIONS IN SYPHILIS, THERAPEUSIS, ETC.

R. W. TAYLOR, M. D.

1. **Bourguet, M. E.** — Syphilis following *bubo d'embrûée*. *Bubo d'embrûée considérée comme accident primitif de la syphilis.* Brochure, Paris, 1874.
2. **Drysdale, C. R.** — Syphilitic albuminuria (case). *Medical Press and Circular*, July 29, 1874.
3. **De Meric, V.** — On some peculiar modes of transmission of syphilis in married life. *British Med. Jour.*, January, 1874.
4. **Hardaway, W. A.** — Pathology of early syphilis. *Missouri Clinical Record*, No. 6, September, 1874.
5. **Hullet, R. B.** — Unity of the syphilitic virus. *Missouri Clinical Record*, September 6, 1874.
6. **Hyde, J. Nevins.** — On some sources of syphilitic infection. *Am. Journal Medical Sciences*, January, 1874.
7. **Jullien, L.** — Virulent bubo of the axilla. *Bubon virulent de l'aisselle.* *Annales de Dermatologie et de Syphiligraphie*, No. 5, 1874.
8. **Jullien, Louis.** — Statistics upon the etiology of tertiary syphilis. *Recherches statistiques sur l'étiologie de la syphilis tertiaire.* Brochure, Paris, 1874.

9. Michel, L.—Case of purulent diathesis developed by syphilis. *Observation d'un cas de diathèse purulente née sous l'influence de la syphilis.* Brochure, Marseilles, 1874.
10. Marsh, H.—Syphilitic disease of the patella. *St. Barth. Hospital Reports*, 1874.
11. Morgan, J.—Modified syphilis. *British Medical Journal*, June, 1874.
12. Popescu, Michel.—Perostitis in secondary syphilis. *Des perostites dans la syphilis secondaire.* Thèse de Paris, 1874.
13. Profeta, G.—Chronology of syphilis. *Sulla svolgimento chronologico della syphilide.* Brochure, Palermo, 1874.
14. Profeta, G.—On the origin of syphilis. *Sulla origine della syphilide.* Brochure, Palermo, 1874.
15. Profeta, G.—Cephalic chancroid. *Sur le chancre non-infectant céphalique.* *Annales de Dermatalogie et de Syphilographie*, No. 3, 1874.
16. Rollet, J.—Inoculated syphilis. *De la syphilis inoculée* *Annales de Dermatologie et de Syphilographie*, No. 5, 1874.
17. Ronchi, Ignazio.—Dualism in syphilis. *Del dualismo ulcerosa in syphilographia.* Madeira, 1874.
18. Smith, Isaac, Jr.—Infection by syphilitic semen. *New York Med. Journal*, November, 1874.
19. Sturgis, F. R.—What effect does syphilis have upon the duration of life? *N. Y. Med. Record*, February, 1874.
20. Woodbury, H. E.—On the communicability of syphilis after it has been apparently cured. *Phil. Med. Times*, February 7, 1874.

BOURGUET (1) endeavors to show that syphilis may have as its starting point the *bubo d'emblée*. The argument itself is weak and untenable, and the cases upon which it is based are badly reported and faultily observed.

DE MERIC (3) reports several cases showing, as he thinks, peculiar modes of transmission of syphilis from husband to wife. In general, he thinks that the wife is contaminated through the offspring rather than by direct contagion, by means of some secreting lesion. The cases are interesting, as showing what is regarded as peculiar by some observers. Case first is that of a man aged 28, who had syphilis, and who for four years, having recurring lesions, underwent treatment. In the following eight

years he had necrosis of the maxilla. He had then been married about ten years, during which time his wife escaped contagion and bore five children. At this period he had an impure coitus, and ten days after cohabited with his wife. Two days after, he noticed a little irritation of the prepuce, which, being neglected, took on a phagedenic character. The wife, in less than two months, developed syphilis, which ran a very severe course. De Meric thinks that the last chancre was of the soft variety, and that the case of the wife bears evidence that a chancroid in a syphilitic subject may communicate syphilis to a virgin soil. The question at issue is certainly one of the most important in syphilitography, but unfortunately it is by no means settled by the present case. De Meric says the sore was of the size of a cherry stone; from this we would infer that it was a nodule. It is certainly within the bounds of probability that the lesion was an ulcerating tubercle, caused by irritation. It is, according to our opinion and experience and to that of others, not uncommon to see ulcerating lesions develop upon syphilitic subjects, particularly upon their genitals, owing to irritation. We have seen such follow chafes, fissures and herpetic ulcers. As the patient of De Meric was undoubtedly syphilitic, the disease retaining its virulence for an uncommonly long period, it is fair to assume that the course suggested was the true one observed here. Such lesions are equally as contagious as are the initial chancre or mucous patch. The description given by De Meric is therefore more in accord with a relapsing tubercle than of a soft chancre. Then, again, the false recurring chancre of Fournier is sometimes developed under such circumstances, and this lesion might have been an example of that rare manifestation. The next case is as follows: A man whose wife is four months pregnant comes under treatment for an indurated chancre of the prepuce. His illicit intercourse took place on the 9th of February, and from the 16th of that month for four weeks he had cohabited with his wife. At the latter date he experienced painful coitus, which caused him to apply for relief. The lesion of the husband was found to be simply a syphilitic chancrous lesion, with very slight secretion; and the important and interesting feature, according to De Meric, is that contagion should result from such a small amount of secretion from a lesion which was so small as to pass for some time unperceived. The last case is not clear in one point. A man has intercourse, without contamination, with a woman for a

number of years. She is found to be syphilitic. After the lapse of several years, the man is troubled with swelling of the cervical glands and difficulty of swallowing. On examination of his throat, there was much inflammation found, and the left tonsil was seen to be hard and swollen. Shortly after, secondary lesions were manifested. De Meric did not find any primary lesion upon the genitals, and concludes that contagion took place at the left tonsil; but he does not offer an explanation of how it probably occurred, though the wife at one time had had secondary lesions about the velum and tonsils.

HYDE (6) makes some pertinent remarks as to syphilitic infection. Alluding to the well-known fact that men often contract syphilis from women upon whom no ulcerating lesion is found, he suggests that perhaps the contagion is due either to menstrual blood or to that issuing from fissures. It may be said, in support of this view, that the contagion of women often results from syphilitic blood coming from chafes or fissures in the male. One of the earliest instances quoted by Waller as tending to show the contagious character of syphilitic blood, was a case in which contagion resulted thus in a wife from her husband. Within a few years, also, Mauriac reports a very convincing similar case. Hyde also thinks that purulent discharges from the vagina and uterus may communicate syphilis. Alluding, also, to a purulent discharge which in early secondary syphilis issues from the penis, he thinks it may be called syphilitic gonorrhœa, and that it may, circumstances being favorable, convey syphilis. It may be interesting to remark in connection with this last subject, which is not generally spoken of in the books (by many being overlooked) that according to the observation of the reporter, who has studied it carefully upon a number of subjects by means of the endoscope, that the discharge is simply the result of an ephemeral congestion of the mucous membrane of the urethra. The condition giving rise to it is similar to that observed in the pharynx, but is more severe in the urethra than in the latter part. The discharge is not the result of any ulcerative lesion, such as the mucous patch, but the appearances observed are similar to those of simple urethritis. In some cases it has been observed to begin spontaneously; in others a remote gonorrhœa has been thought to predispose to it.

MARSH (10) reports the case of a man aged 29, who had syphilis eight years previous. Four years after he struck his left knee

upon a box, causing pain and swelling. Six months after, there being no pain in the interval, he found the patella to be swollen and very painful at night. When examined, the bone was found to be enlarged in all of its measurements, the integument over it being of a dusky red color. Under the use of iodide of potassium the size was slightly reduced but the pain was relieved.

MORGAN (11) in a measure goes back to the doctrine of Carmichael, to the effect that various forms of syphilitic sores have different sequelae or manifestations. His views differ, however, in certain particulars. He is a disbeliever in the doctrine of dualism, and while he acknowledges that constitutional manifestations follow an indurated ulcer, he thinks that milder constitutional symptoms follow the non-indurated sore. He says that he often sees soft *patchy* sores in the male followed by general infection, and he thinks that the syphilitic cachexia induced by such a lesion is milder than when following a hard sore. He alludes to the fact that induration is usually wanting in the infecting chancres of women, and states that he, as well as other observers of large experience, always entertain a reservation in pronouncing upon the syphilitic character of a given sore in the female. His view of the origin of the peculiar syphilitic soft sore of the female is that it is the result of a worn out syphilis (if we may thus term it) in women who have led a degraded life, cohabiting for years with soldiers. He terms this condition as that of "women having fallen to the lowest order, and who have been saturated with the syphilitic taint." He reiterates his old statement, that if the secretion of such sores is inoculated upon their bearers, typical chancroids are produced. This result, he thinks, demolishes the doctrine of dualism. It may be well to state that he supports this view by the fact that he can (as can others, who have done the same) produce ulcers upon syphilitic persons appearing in all respects like chancroids, by the inoculation of the purulent discharge from the genitals of a syphilitic woman who has no ulcerating lesion. It may be here stated that the fatal and lacking point in his theory is this, that he *has never, with such pus, produced in a non-syphilitic subject a chancroidal appearing sore, which was undoubted in all its characteristics, and which was followed by syphilis.* If he could establish this point, he would demolish dualism entirely, but he has not done so. It is to be suggested to those who read these remarks made by Morgan, particularly to those not extensively read in these

matters, that they only hear from him one side of the theory, and that one of prejudice, and that if they will follow the reading of his article by a perusal of Fournier's chapter upon the induration of chancres in the female, in his work upon Syphilis studied in the Female, it will be seen clearly that what are considered by Morgan as objections fatal to the dualistic theory, are readily and forcibly accounted for, and that, in reality, there is no foundation for such objections if cases are skillfully and scientifically studied and observed without prejudice. In justice to Morgan, it must be conceded that he is endeavoring to arrive at correct conclusions as to these questions, and that he has had extensive experience; yet in his productions there is evidence of an absence or clearness of reasoning and a want of proper analysis of his cases, so that his conclusions strike the reader as hasty and confused. This fact is especially well shown in a work upon the contagious diseases, published some years ago. Two army surgeons follow up Morgan's article by short papers, in which they speak as being in accord with his views; but it can be readily seen that if a surgeon, thoroughly versed in all venereal diseases, were to observe the same cases, he would not find any obscure points connected with them, or indeed any which could not be easily reconciled with the prevailing doctrine of dualism. The articles by the latter are published in the British Medical Journal; one by U. S. Oliver, in May, 1874, the other by J. Porter, July of the same year.

Dr. MICHEL POPESCU (12) gives the result of his studies, under the guidance of M. Fournier, upon *periostitis in secondary syphilis*, which has recently been well described by Mauriac. His conclusions are:

1. Syphilis in its secondary stage produces perceptible alteration of bones, called *periostoses*. They are, however, but one of a multitude of lesions visceral, fibrous, nervous, etc.

2. These secondary periostoses are characterized by an elevation having a true bony hardness, never going on to suppuration and almost always undergoing resolution in a short time, being accompanied by other secondary manifestations.

3. Syphilitic pains, osteoscopic cephalgia, costal pain, and intercostal neuralgia, are often accompanied by periostitis which may be considered as their immediate cause. The tumors and pains disappear under the influence of treatment.

The author states the interesting fact that the parietal bone was

the seat of periostitis but three times in forty cases, and the occipital bone but once; the frontal bone seems to be the one most liable to be affected; this is in accordance with our experience. We think that the author states the case too broadly when he says that these precocious tumors never undergo degeneration; in our experience this accident, though rare, certainly has been known to occur, particularly when the swellings are seated upon the sternum. These periostoses are developed coincidently with the evolution of the secondary lesions; their progress is slow and their duration generally from one to three months; the shortest period known being ten to fifteen days, and the longest being an exceptional case of five years. Relapses have been known to occur in three cases. The work is carefully written, and is a quite interesting contribution.

PROFETA (13) reports with circumstantial minuteness three interesting cases of cephalic chancroids which came under his own observation. They ran a chronic course, were somewhat serpiginous in character, and produced much deformity. The interest, besides the diagnostic consideration, of these cases, is very great in the weight which they carry with them against a theory once largely entertained, that there was an immunity of the cephalic region to chancroidal ulceration. The reporter, two years ago, detailed a case in which a chancroid in an active stage was observed upon the cephalic region. The grand result of the publication of all of these cases is to prove beyond any doubt that the integument of the head is almost equally as susceptible as that of any other part of the body to this form of ulcer.

SMITH (18) thinks that a case which he has observed proves that syphilis may be communicated by the semen. The facts as given are as follows: In February, 1872, a man has a chancre, which heals and leaves a cicatrix. Secondary manifestations follow, of which he is cured by treatment. In a year, being apparently healthy, he marries, and six months after, he seeming well, discovers an ulcer upon the os uteri of his wife, she having severe prolapsus. The ulcer proves to be a chancre, and is followed by secondary lesions. Some months after the contamination of the wife, the husband has an ulcer on his penis, without having had intercourse with any other woman. Smith thinks that the contagion of the wife surely occurred by means of the semen, and that this case controverts the view that semen cannot communicate syphilis. It is certainly positive that the woman

became syphilitic by means of this uterine chancre, but it does not by any means follow that the chancre was caused by semen. On the contrary, it is very probable that contagion took place by means of blood from a minute excoriation or fissure upon the penis of the male. The man's history shows that he was still syphilitic; hence, his blood would be contagious, and slight abrasions or fissures would not attract any especial attention, as they so frequently occur. The gist of the matter is this, that we know that the blood is contagious, and we think that the semen is not; now Dr. Smith cannot claim to have established his proposition until he has clearly proved that contagion did not take place through the blood. It may be added as confirmatory of the latter view that the os uteri was in a condition of inflammation; hence, it was more than usually susceptible to the transudation of fluids.

STURGIS (19) contributes an interesting paper on the influence of syphilis upon life. His inquiry is directed to the development of facts relative to life insurance, and is largely based on statistics. His conclusions are as follows: 1. Syphilis destroys life by exhaustion and non-assimilation. 2. Renders persons more liable to other diseases by reason of its deposits and their degeneration. 3. A small proportion of syphilitics suffer from late lesions. As to the propriety of insuring persons, he thinks: 1. It is better to refuse those still under the influence of the disease, but that after cure they may be accepted. 2. An average of four years from contagion in auspicious cases should elapse before the acceptance of a person. 3. Hereditary diathesis and visceral syphilitic lesions, though serious conditions need not, if recovered from, act as a bar to insurance. 4. Persons hereditarily syphilitic should not be accepted. 5. Require the certificate of the person who healed the case.

WOODBURY (20) reports a case of syphilis in a woman, the origin of which he is unable to explain; and three other physicians who saw it in consultation failed to aid him, except by deepening his doubt and suspicion. It is briefly as follows: A man, in the spring of 1870, became syphilitic. Under treatment, he was considered to be cured in 1872, when, presenting no lesions, he was married. His freedom from syphilis was not real, as he was attacked by a syphilitic ulcer six months after. Two months after his marriage, he called Dr. W.'s attention to a painful sore on his wife's genitals, and "some very suspicious symptoms."

No further history of the wife is given; it is to be inferred from the context, however, that she was syphilitic. The woman declared that she was chaste, and the husband asserted his continence, and, after examination, it was found that he was free from lesions of the penis. The question is, how did the woman become syphilitic? Dr. W. says: "We can only add that in this case *some deception must have been practiced or some mistake made, as we verily believe.*" The italics are by Dr. W. There are certain reasons why this case should be looked into critically. We can readily understand from the statement that the husband doubted the wife and the wife the husband. Now, particularly in newly married people, chafes and fissures are liable to occur on the genitals, and if either one of them is syphilitic the circumstances are favorable in a high degree to syphilitic infection, for we know beyond a doubt that the blood is highly contagious. This husband was undoubtedly syphilitic, and though he was found to be free from lesions some weeks after his wife's contamination, it is not at all improbable that he had a chafe or fissure at the time, from which blood escaping contaminated his wife. At any rate, as the supposition is so appropriate in such a case, it should be suggested, and this would have saved a perhaps innocent woman from the suspicion of unchastity.

#### THE TREATMENT OF SYPHILIS.

1. **Badia, Salvador.**—Hypodermic injections in syphilis. La curacion de la syphilis por las inyecciones de bichlorido hydrargyrico. Brochure, Barcelona, 1874.
2. **Carat, P.**—Iodide of ammonium in syphilis. Usage de l'iodure ammonium dans la syphilis. Gazette Hebdomadaire, Nos. 10 and 12, 1874.
3. **Fothergill, J. M.**—Use of mercury in some of the obscurer forms of syphilis. Practitioner, Nov., 1874.
4. **Guenel, A.**—Mercurial frictions in the severe forms of syphilis. Frictions mercurielles dans le traitement des forms graves de la syphilis. Thèse de Paris, 1874.
5. **Maury, F. F.**—Treatment of chancre. N. Y. Med Record, Nov. 2, 1874.
6. **Profeta, G.**—Iodoform in venereal ulcers. De l'emploi de l'iodoforme dans le traitement des ulcers vénériens. Annales de Dermatologie et de Syphiligraphie, No. 6, 1874.

7. **Schutzenburger.** — Radical cure of syphilis by sub-acute, hydrargyrosis. *De la cure radicale de la syphilis par hydrargyrose subaiguë.* *Gazette Med. de Strasbourg et Lyon Medical,* July, 1874.

8. **Sigmund, C.** — Proper time to commence the treatment of syphilis and the choice of the method. *(Giornale Ital. della mal. ven. e delle Pelle,* Feb., 1874.

9. **Tachard.** — Treatment of syphilis by the hypodermic method. *Traitemenr de la syphilis par la méthode hypodermique.* *Brochure, Toulouse,* 1874.

10. **Woodbury, H. E.** — Treatment of venereal buboes *Phil. Med. Times,* Oct. 10, 1874.

FOTHERGILL's paper (3) is a cursory but sensible contribution to the management of late acquired and hereditary syphilis. Recommending avoidance of the noxious action of mercurials, he advocates a prolonged course of treatment. The value of the simultaneous administration of haematics, as well as their want of power, if given alone, is well brought out; while the necessity in some cases for a combination of mercury and iodide of potassium is spoken of. It is unfortunate that so much looseness of expression is employed as to the action of medicines upon syphilis; thus, we find the author speaking as follows: "The syphilitic virus has not merely to be compelled to withdraw itself into obscurity; it should be followed up and exterminated, while the system generally and the general health should be well supported during the whole eradicating process."

GUENEL (4) gives the following as his conclusions as to the value of mercurial frictions in severe forms of syphilis: Frictions used according to a rational method have some of the drawbacks which have been attributed to them; they have the advantage that they do not disturb the alimentary canal; they very often succeed in cases where internal treatment has failed; they should be used immediately in severe forms of syphilis when the lesions compromise the life of a patient, or an important organ; it is especially in the lesions of the cerebro-spinal centres and of the eyes that they are most prominently indicated; they are as successful in the tertiary as in the secondary stage.

A statement occurs in MAURY's lecture (5) which is so much at variance with the doctrines now regarded as correct, that we think attention should be called to it. The author's words are as

follows: "If treatment of chancre can be instituted within five days after exposure, the chances are very good that the patient may escape from constitutional symptoms; but after five days have elapsed, it is not safe to predict a perfect cure under any circumstances whatever. By way of illustration, if a patient should present himself with a chancre eight or ten days after exposure, local applications should be made as soon as possible in the way of cauterization, and constitutional treatment at once adopted if the chancre is hard; but guarantee of perfect cure cannot be made with safety." The first of these sentences conveys the impression to the reader that the author regards all chancres as syphilitic; but his recommendation that treatment should be adopted if the chancre is hard, seems to indicate that he himself is not certain of his ground. It seems somewhat remarkable that at this late day, when the view which was discarded by Record and others years ago, that very early cauterization of chancres prevented the infection of the enconomy, should be taught by a prominent teacher in a college of good standing. A few words will clearly show how untenable such a position is. If the chancre is syphilitic in its nature, it does not show itself until at least one week has elapsed after the contaminating connection. This fact is undoubted. At this time, the infection, if not complete, has certainly gained such a foothold in the system that nothing short of excision of the morbid spot and extirpation of the inguinal ganglia in immediate connection with it, will afford any thing like immunity to syphilis, and it is doubtful if this radical treatment would produce the result. How then can the above statement be true? Berkeley Hill's experience shows that thorough cauterization within twelve hours of a slight fissure on the penis, which had been formed while its bearer had been cohabiting with a syphilitic woman, utterly failed to prevent syphilis in him, how much more futile will such a proceeding be if attempted, say, at the earliest moment at which the chancre is recognizable, which is six to ten days. As we know beyond a doubt that chancroid (supposing the diagnosis of such to be correct) is not followed by syphilis, what is the benefit to be derived from early cauterization as a prophylactic? Of course, the proper treatment of such an ulcer consists in early and thorough destruction by escharotics; but it is not in accordance with facts to suppose that we are thus preventing syphilis. We call attention to these points, as we think that such statements should not pass unchallenged, as if indorsed by general consent.

SCHUTZENBURGER (7) believes that syphilis may be radically cured by a medication which he calls sub-acute hydrargyrosis, or a mercurial treatment, slow, prolonged and insensible to the patient. He does not lay great stress upon the choice of the preparation, or of its mode of administration ; what he desires to do is to act rapidly and surely upon the system. On the whole, he perhaps prefers frictions. He uses a preparatory treatment, such as baths, sudorific decoctions and purgatives ; then he begins by rubbing into the integument from 30 to 90 grains of mercurial ointment every second day. He thinks that 20 to 25 such frictions are necessary. Should salivation occur and be troublesome, it is necessary to stop treatment, but the frictions should be continued in spite of mild buccal symptoms. He claims that he has cured many severe cases.

SIGMUND (8) again states his views as to when to treat syphilis and as to the method of doing it. He gives the following rules as warranted by his experience : 1. The methodical general treatment of syphilis should be, as a rule, commenced when undoubted signs of the general disease are manifested (at the evolution of secondary lesions). 2. Mercurial preparations are to be preferred. 3. Treatment should be kept up uninterruptedly or periodically, according to circumstances, as long as the symptoms of the disease persist or reappear. 4. Intercurrent diseases should be treated, as in a non-syphilitic subject. 5. Hygienics and tonics should be used in each case, and diet should be supporting. Giving preference to inunction, he also advises hypodermic injections. He has used with advantage calomel subcutaneously, and thinks that by using small quantities abscesses are avoided. He recommends care in administering medicine to patients, and avoidance of overdosing. He does not think highly of the iodide of potassium as an anti-syphilitic, but says that it may be used as an adjuvant.

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## NERVOUS AND VISCERAL SYPHILIS.

E. L. KEYES, M. D.

1. **Aufrecht.** — Cases of syphilitic miliary tuberculosis. Deutsche Ztschrft. f. prakt. Med., 1874, 26.

2. **Barety.** — Atrophy of the interosseus muscles of the hand in two syphilitic patients. Annal. de Derm. and de Syph., 1873-4, Nos. 3 and 4.

3. **Bjorkin, John.**—Case of cerebral syphilis. *Upsala läkare-fören förhandl.* 1874, 6, p. 534.
4. **Briere.**—Paralysis of third, fourth, fifth, sixth and seventh cranial nerves on the right side; tumor at the base of the cranium (in the pharynx), probably of syphilitic nature. Failure of treatment; death; no autopsy. *Gaz. des Hôp.*, Sept. 24th, 1874.
5. **Busey, Saml. C.**—Case of syphilitic dactylitis in a child 18 months old (wood-cut). *Am. Jour. Med. Sci.*, Oct., 1874.
6. **Buzzard, Thomas.**—Case of double facial paralysis, with paralysis of all four extremities, general anæsthesia, incomplete paralysis of respiration and deglutition, paresis of the bladder, cure by antisyphilitic treatment. *Transactions of the Clinical Society*, 1874, p. 74.
7. **Ford, Willis E.**—Clinical cases, syphilitic insanity. *American Journal of Insanity*, July, 1874, p. 73.
8. **Gallard.**—Syphilitic affection of the spinal cord treated with iodide of potassium and galvanism. *L'Union* 135, 1874.
9. **Jackson, J. Hughlings.**—Two cases of intra-cranial syphilis. *Jour. of Mental Sciences*, July, 1874, p. 235.
10. **Lacombe.**—A study of the syphilitic lesions of the liver in the adult. *Paris Delahaye*, 1874.
11. **Mauriac.**—Early gummy syphilides resisting the iodide of potassium. *Gaz. des Hôp.*, 1874. 72-73-76 (continuation and conclusion).
12. **Southey, Reginald.**—Bright's disease in syphilis. *Transactions of the Clinical Society*, 1874, p. 9.
13. **Tuke, J. Batty.**—Remarks on a case of syphilitic insanity. *Journal of Mental Sciences*, January, 1875, p. 560; July, 1874, p. 262, and Oct., 1874, p. 352.
14. **Weil.**—Tumification of the spleen in the earlier periods of syphilis. *Centralbl. f. d. Med. Wissenschaft*, 1874; 12, p. 177.
15. **Weil.**—Same as above, with remarks on percussion of the spleen. *Deutsch. Aschiv. f. Klin. Med.*, May 15th, 1874.

BARETY (2) gives the interesting history of a case where an extensive syphilitic exostosis in the cervical portion of the vertebral column, in a sewing woman of 47, was followed, after existing three years, by gradual loss of power (nearly to extinction) in both upper extremities, subsequently to a less extent in both lower limbs. The interosseous muscles of both hands became greatly

atrophied, but did not cease to respond to electricity. Treatment by inunction and increasing doses of the iodide of potassium restored nearly complete motion to the lower extremities, and after four and a half months produced striking amelioration in the upper limbs, while the interosseous muscles nearly regained their size and resumed their functions. The exostosis did not disappear. B. concluded that the morbid growth of bone was located for a time (3 years) solely on the outside of the column, but finally extending within and pressing upon the emerging nerves, paralytic symptoms had supervened. The atrophy was arrested in this case, but the patient did not recover sufficiently to resume her trade (sewing). B. reports another case where two gummata appeared, one at the middle internal portion of the arm, the other at the lower border. Cutaneous anesthesia of the hand, especially of the last two fingers, ensued with atrophy of the interosseous muscles. Numerous other syphilitic lesions were present (among others icterus), but the muscular atrophy persisted in spite of repeated anti-venereal courses and, later, the use of electricity. A curious feature of the case is that about every three months phlyctenoid vesicles appeared along the internal border or at the extremity of the little finger.

The syphilitic history and antecedents of BUSEV's case (5) are less definite than desirable. The swelling was at the metacarpophalangeal articulation of the middle finger. Anti-syphilitic treatment was followed by marked improvement.

Five new clinical cases of syphilitic insanity are contributed by FORD (7), of which the first is specially noticeable, in that the attack occurred during the period of secondary eruption, only four months after chancre. The mental aberration consisted in melancholia, dejection, despondency, delusions concerning attempts upon his life, and strong impulse to kill his associates; suicidal tendencies. He came to the asylum voluntarily, displayed great emotional excitability, extreme restlessness, etc. A limited sojourn in the asylum effected a cure under anti-syphilitic remedies.

JACKSON's cases (9) are corroborative of what we already know of the tendency of syphilis of the nervous system to produce varied and incongruous phenomena, or what, in these cases, is alluded to as a "random succession of symptoms." In the first case the symptoms were paralytic, convulsive and intelligential, all of which the patient attributed to a blow on the head, denying

syphilis. The autopsy revealed nodules in the testis, cicatrices in the liver, extensive alteration, thickening, etc., of the arteries at the base of the brain, both anterior cerebral arteries blocked up and several spots of softening of brain substance due to plugging of the arteries supplying them, which doubtless accounted for the suddenness of some of the patient's attacks. The second patient also denied syphilis, but a post-mortem examination proved the error, as did also the symptoms of inherited disease evinced by the patient's daughter. A point of peculiar interest in this case is the existence of double optic neuritis, with no evidence that the sight was impaired. J. takes occasion to insist upon the necessity of routine examination of a patient suffering from any nervous symptoms due to syphilis, especially if there be pain in the head, to detect optic neuritis early, and be able, haply, to ward off amaurosis. He lays stress also upon a point which Buzzard thinks of value, that optic neuritis with one-sided convulsions points strongly toward syphilis. At the autopsy, several small gummy tumors were found, with evidences of arteritis and several spots of softening.

LACOMBE brings out (11) what is known up to date, advancing but little new. He speaks, however, of a perilymphangitis due to syphilis, an increase in the number of vessels, which are dilated and surrounded by a ring of connective issue. L. believes the icterus accompanying the earlier symptoms of syphilis to be due to gastro-intestinal catarrh and comes out strongly for the identity of diffuse hepatitis and gummy tumor of the liver, believing them to be stages of an identical process.

TUKE (13) takes up in the July and October Journal the history of the case first reported in January, 1874—insanity with hemiplegia, etc. An unusual clinical feature of the case was that both pupils were "persistently much contracted." Post-mortem there were found localized atrophies of grey matter of cerebral convolutions, two clots in the right hemisphere, and very general arteritis; some of the vessels were obliterated. Several chromolithographs of sections of vessels accompany the article.

WEIL's (15) second article on *syphilis of the spleen* is an expansion of the first (14) and contains in addition plates and directions for percussing the spleen. After touching upon gummatous and amyloid degeneration and the indurated and soft (Virchow) forms of splenic hyperplasia appertaining to later syphilis, and recognizing the clinical value of the splenic tumor (Gee, Eisen-

schitz and others) in the diagnosis of hereditary syphilis, the author goes on to notice three cases of early syphilis, two of which entered the hospital soon after infection, "three or four weeks before the outcropping of the earliest exanthem," and the other four weeks after the appearance of a roseola. In each of these cases the splenic tumor, as shown by percussion, was already large on admission into the hospital; in one case it could be plainly felt. Specific treatment removed the tumors in five to ten weeks. The absence of any other cause for the enlargement and the effect of treatment, are the author's reasons for attributing the affection to syphilis. In other cases of early syphilis in which he searched he failed to detect any splenic tumor. He ranks the affection with acute swellings of the spleen, and believes it anatomically to consist of an increase of the cell elements of the pulp with hyperæmia.

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## SYPHILIS OF THE MOUTH, THROAT AND LARYNX

GEORGE M. LEFFERTS, M. D.

1. **Godon, F. W.**—A case of syphilitic ulceration of the œsophagus. Diagnosis by Hamburger's method of Auscultation. Pacific Med. and Surg. Jour., Feb., 1875.

2. **Landrieux, M.**—Syphilitic angina—ulceration of the internal carotid. Bull. de la Soc. Anatom. de Paris. Juillet, 1874.

3. **Morgan**—Laryngotomy in syphilitic affections of the air passages. Irish Hosp. Gazette, Feb., 1874 (Compendium of the Med. Sci., July, 1874).

4. **Norton.**—Syphilitic gummy tumor of the larynx. Abscess, œdema glottidis, death. Path. Soc., London. Brit. Med. Jour., May 16, 1874.

5. **Rey, Alfred.**—Tracheal syphilis (Etude sur la syphilis trachéale). Delahaye. Paris, 1874.

6. **Report of 18 cases** of syphilis of the larynx and pharynx treated in the Throat Department during 1874. Annual report of the N. Y. Eye and Ear infirmary, March, 1874.

7. **Tobold, Adelbert.**—Laryngitis syphilitica—Laryngoskopie und Kehlkopfkrankheiten. Berlin, 1874, pp. 283, 306.

8. **Tobold, Adelbert.**—Syphilitic cicatricial stenosis of the pharynx. Tracheotomy (Tracheotomie bei syphilitische Narben Stenose des Rachens). Deutsche Klinik, 1874, p. 206.

9. **Zeissel, H.** — Treatment of syphilitic ozœna (Die Behandlung der ozœna syphilitica). All. Wien. med. Zeit. No. 44, 1874.

10. **Zeissel, H.** — Angina syphilitica catarrhosa, gummata of the soft palate, syphilis of the tongue, of the post pharyngeal wall and the pharynx, of the larynx, syphilitic hypertrophies of the mucous membrane of the larynx, syph. affections of the trachea and of the nasal mucous membrane. Lehrbuch der Syphilis. Stuttgart, 1875, pp. 199-224.

11. **Zeissel, H.** — Angina syph. erythematosa, syph. palati, syph. pharyngis. Tafel XXI. Fig. 1, 2, 3. Syph. palati, gummata of the lower lip. Tafel XXII. Fig. 1, 2. Delineations — Atlas to above.

GODON's (1) patient, a feeble and poorly nourished man, who had suffered from constitutional syphilis some twenty-four years previously, applied, in October, 1874, for relief from a dysphagia which had lasted for six weeks, and which was gradually becoming worse. There was no evidence of lung trouble, and the pharynx, larynx and orifice of the œsophagus were found to be normal. Auscultation of the œsophagus, while a mouth full of water was being swallowed, demonstrated that the water, after reaching a point opposite the fifth dorsal vertebra, was regurgitated with a loud splash; the fluid was not, however, thrown up into the mouth, but after a few seconds passed down a second time beyond the point of obstruction, and finally reached the stomach. During the passage of the liquid, a trickling or dropping could be heard over the seat of the stricture. The act of deglutition occupied some five minutes. A No. 8 bougie was caught in a tight stricture at the junction of the lower and middle thirds of the œsophagus, and on withdrawing it a slight bleeding followed.

After a fortnight's treatment by iodide of potassium and ice, the patient could swallow fluids comfortably and solids slowly, but not without pain. On auscultation it was found that the liquid passed with less difficulty, and, although the passage over the lower part of the canal was slow, there was no dribbling, and only a slight regurgitation with no great delay, at the point of stricture.

Two weeks later the stethescope showed that a distinctly rough sound was present as the fluid in deglutition passed over the point of the former stricture at the fifth dorsal vertebra. A No. 8 bougie was passed through the seat of the stricture without difficulty, and withdrawn without bleeding. The patient was dismissed at his request, a guarded prognosis being given.

In LANDRIEUX' (2) interesting case the patient had been a sufferer for two years from an ulcerative pharyngitis, syphilitic in its nature, which had resulted in a general and wide-spread hypertrophy and induration of the pharyngo-laryngeal tract. At the sides of the pharynx and over the location of the pillars of the fauces, two large fleshy masses existed. During the course of the disease gummy tumors had appeared upon various parts of the body, especially the legs, but had yielded readily to an anti-specific course of treatment. Treatment had, however, no effect upon the condition of the pharyngeal parts. Eight days after admission to the hospital, the patient had an attack of hæmoptysis, for which no appreciable cause could be found. This was followed, two days later, by a second, during which the patient died. On the autopsy, gummy tumors of several of the viscera were found. In the pharynx marked hypertrophy of the tissues, associated with chronic ulcerative processes. Periostitis and erosions of the anterior faces of the bodies of the cervical vertebræ. Laterally, on the left side of the pharynx, a lineal ulceration existed, extending outward, and forming a communication between the trunk of the internal carotid artery and the pharynx.

TOBOLD (7) quotes the following figures from Sommerbrodt to demonstrate the frequency of *laryngeal affections during the course of a constitutional syphilis*. Rühle among 100 syphilitic cases found 15 with laryngeal complications, while Altenhöfer records only 25 out of 1,200 examinations. Gerhardt and Roth report 56 cases, out of these 44 being affected with early syphilitic symptoms, 11 suffered from laryngeal disease; out of 12 with the late, so-called, tertiary symptoms, 7 had laryngeal trouble. Engelsted observed "laryngeal affections" in 521 syphilitic patients 25 times, 14 cases among 292 males, and 11 cases among 229 females. Sommerbrodt found in the examination of 84 patients suffering from constitutional syphilis, 15 with ulcerations of the larynx and 14 with catarrhal affections. Tobold reports that out of 830 cases which he has observed, 660 patients were found to have laryngeal complications, 420 with ulcerations, and 170 affected by some degree of the inflammatory process. The shortest time between the period of infection and the laryngeal affection varies between two and six months, generally the interval is longer. Tobold also states that he has observed cases in which the date of the primary lesion could be carried back 15 years. Türck has found syphilitic ulcerations in the larynx 20 years after the primary lesion.

The presence of the so-called "condylomata," and the tertiary ulcerations, allow of a laryngoscopic diagnosis being made with certainty.

The condylomatous growths present themselves in two forms in the larynx, either as flat, or as pointed, projecting outgrowths. They first appear as small, flat, whitish gray, warty elevations, principally on the posterior portions of the vocal cords and the posterior wall of the larynx, less frequently on the ary-epiglottic folds. The latter show themselves as reddish, smooth, rounded prominences, of a firm appearance, and, according to Tobold, occur only on the posterior wall of the larynx. He further states that the opinions of observers vary greatly regarding the occurrence of the "broad condylomata" in the larynx. For instance, while Gerhardt and Roth claim to have seen them on the mucous membrane between the arytenoid cartilages, other authors, viz.: Semeleider and Sommerbrodt deny the possibility of their presence, stating that exactly on that point where the former believe to have seen them, the first condition necessary to their production, namely, the papillary body, is wanting.

Tertiary ulcerations have an irregular, sharply marked outline, projecting, deeply reddened edges and bases covered by a dirty yellowish secretion. The termination of these ulcerative processes varies greatly, if they be superficial they heal without loss of substance, and the epithelium which has been lost is fully regenerated. If, however, the ulcer has extended into the submucous tissues, cicatrization will show a marked loss of tissue—the cicatrix has a marked tendency to contraction, and may alone cause a laryngeal stenosis.

Syphilitic ulcers of a sinuous and irregular form are found in the trachea, and, according to Rockitansky, even in the bronchia.

Tobold differs from Cohn in regarding the painfulness of syphilitic ulcerations as one of their characteristics, and states that he, as well as Türck and Sommerbrodt, have observed exactly the contrary, and that the immunity from suffering in a patient, even with extensive ulceration, gives a differential diagnostic point between this disease and tuberculous ulceration. In respect to treatment Tobold believes that in all syphilitic laryngeal ulcerations a general anti-syphilitic course is all important; he generally gives at first the iodide of mercury unless this or similar preparations have been used unsuccessfully within a short time, or unless the constitution of the patient has suffered from the long continued

use of mercurials. In a case in which a rapidly spreading ulceration is to be feared, he prefers from the beginning to use the iodide of potash. Schnitzler and Sommerbrodt commend the treatment by inunction. Tobold adopts it combined with the use of the decoct. Zittmanni, in such cases as are complicated with other syphilitic manifestations. (Iritis, enlargement of glands, eruptions.)

Superficial ulcerations may be treated locally by pencilling them with mild astringent solutions, while for the severer forms, cauterization with strong solutions of nitrate of silver are recommended.

Schnitzler has lately used with success, for the syphilitic ulcerations of the larynx the local application of tinct. iodine, or a combination of iodine, iodide of potash, and glycerine.

The same author (8) relates the history of a case of cicatricial stenosis of the pharynx which required the performance of tracheotomy, on account of the urgent dyspnœa which it caused. The patient, a woman aged 57, had suffered some twelve years previously from a severe inflammation of the throat (an ulcerative syphilitic pharyngitis), and since that time deglutition had been affected, and had become progressively worse. Six years after the primary attack a stenosis of the pharynx had been diagnosticated, but no treatment had been undertaken to relieve the condition.

The dyspnœa, from which she suffered at the time of her admission at the clinique, was excessive, and deglutition was nearly impossible. The soft palate, through extensive ulceration, was irregularly destroyed and attached by cicatricial bands to the dorsum of the tongue and the posterior pharyngeal wall, a small canal only, admitting a small-sized probe, leading downward to the superior opening of the larynx. The latter could not be seen in the laryngoscopic mirror. Nine weeks after the operation of tracheotomy, a systematic division of the cicatricial bands and adhesions, by means of strong curved scissors, was undertaken, and the result was so favorable that three months later the patient was able to dispense with the tracheal tube.

## Reviews and Book Notices.

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*A practical treatise upon eczema, including its lichenous and impetiginous forms.* By Dr. M'CALL ANDERSON, 3d edition. London : J. A. Churchill, 1874.

We have read through, with much pleasure, the third edition of Dr. Anderson's admirable monograph on eczema, and can bear testimony to the truthfulness of the clinical pictures drawn and to the value of the treatment recommended. Unfortunately, however, in the attempt to present the pathological anatomy of eczema, the author has by no means sustained his reputation as a writer and student. The explanations are not clear, and the illustrations—all borrowed from Neumann, Rindfleisch and Biesiadecki — are thrown together in such a manner as to confuse rather than elucidate the subject to those not accustomed to such studies.

It is to be regretted that the more recent writers have not attempted new investigations in this line. It is known most of the statements as to the development of eczema have been based on the experiments of Neumann, who rubbed croton oil into the ear of a living white rabbit, and then watched the result for several hours with the aid of a low power of the microscope. Now, we question very much if the process of inflammation then and there induced corresponds exactly to eczema in the human subject. We can by no means consent to call every superficial cutaneous inflammation, artificially produced, an eczema. Other factors are necessary, and while irritation of the skin, as with croton oil, might *induce* true eczema in one predisposed thereto, in many others but a simple dermatitis would follow. Dr. Anderson himself seems to overlook this, as he states distinctly, p. 31, "we know well that scratching the healthy skin is quite capable of producing an eczematous eruption," which might better be modified, we think, by adding, "in persons with a tendency to eczema."

Our author states that arsenic given to a nursing mother will furnish an antidote to the complaint of the child at the breast, a statement which we should be glad to see verified, but of the truth of which we entertain serious doubts. We must also criticise the use of the term syphilitic eczema, which is no more proper than syphilitic lichen, impetigo, psoriasis, etc., a confusion of names being perpetuated by this union of words. Syphilis, we hold, can never

produce true eczema, psoriasis or lichen. He distinctly calls the *impetigo contagiosa*, first accurately described by Tilbury Fox, but a "form of eczema," p. 65. The disease, as we have seen it, certainly possesses but little in common with the latter affection.

We cannot here further analyze the work. The points of criticism are but few, the book is a credit to the science of dermatology, and we can only wish that all other diseases of the skin were as carefully and practically worked out. We heartily commend it to our readers.

*Practical and theoretical treatise on the diseases of the skin.* By GEORGE NAYLER, F. R. C. S., Surgeon to the Hospital for diseases of the skin, Stamford street, Blackfriars. Second edition. London: Smith, Elder & Co. New York: G. P. Putnam's Sons, 1874.

This work is chiefly valuable as giving the views and experience of one who has had a very large experience in skin diseases. His views both as regards nature and treatment, are well stated, and the work is a valuable addition to the literature of Dermatology. His classification is rather behind the age, and the volume though a large one is not by any means a complete treatise. Following Startin he devotes a chapter to Porrido, a name not often used at present among dermatologists. The remarks on treatment are valuable. The illustrations, though few in number, deserve special commendation. The drawing by Maddox representing the mycelium found in a case of favus is especially good; altogether it is a valuable work. As regards printing, paper, etc., the publishers have done their work well.

*Cutaneous medicine and diseases of the skin.* By H. S. PURDON, M. D., Belfast. London and Belfast: 1875, pp. 272.

Whilst this little volume cannot take the place of the larger and more complete works we already possess, yet it contains much valuable material and shows the author's knowledge of his subject. It will well repay a careful perusal.

*Medical and Surgical uses of Electricity.* BEARD & ROCKWELL. Second Edition. New York: Wm. Wood & Co., 1875.

The subject of the electrical treatment of diseases of the skin and genital apparatus, is one which is attracting considerable attention at present, and the volume before us, giving 74 pages to clinical subjects relating to dermatology, represents by far the most complete notice taken of this branch in any work on electricity. This, together with the simple and practical general instructions as to the science and practice of electrology make the work valuable to all devoted to the treatment of diseases of the skin, as well as to the

general practitioner. The experiences are very largely those of the authors, and some little allowance must often be made for extravagance of expression as to the benefits derived from this method of treatment, as compared with others well known. It is but proper to state that the agent has not been as serviceable in the hands of others as one might be led to imagine it would be from reading the work. We must criticise the diagnosis of elephantiasis in the case so named, on page 572.

The work is elegantly gotten up, and should be possessed by every one who desires to learn quickly and easily the methods of using electricity.

*Lectures on skin diseases.* By E. D. MAPOTHER, M. D. Second edition. Dublin : Fannon & Co., 1875.

This is a small volume of 212 pages, and consists of six lectures delivered at the Royal College of Surgeons. It does not claim to be a special treatise on diseases of the skin. It takes up only a portion of the subject and we do not think it has any special claims for excellence even in those of which it treats. It was rather a waste of time, etc., to issue the lectures in book form.

*Syphilitic Disease of the Cerebral Arteries; with general observations upon the normal and pathological Histology of the arteries, and upon the Cerebral Circulation.*

Die Luetische Erkrankung der Hirnarterien, etc. Von Dr. med. O. HEUBNER, pp. 238. Leipzig : 1874.

This work will, it is believed, direct attention to a common form of syphilis of the nervous system which has been hitherto but little studied, and which is altogether ignored by many practitioners.

In 1870, Dr. E. L. Keyes,\* of this city, published a very valuable essay on syphilis of the nervous system, chiefly a clinical and therapeutic study; and in it he does not speak of arterial lesions.

Lancereaux in his last edition, while giving much space to syphilis of the circulatory organs and of the nervous system mentions the condition studied by Heubner, but without attaching to it the attention it deserves.†

In the last two years the reviewer has several times called the attention of students to cases of brain-syphilis, and explained many of the symptoms present by the existence of arteritis. These cases with others may be published in a future number of this journal. The lesions produced by syphilis in the nervous system are ordinarily considered to be periostitis, meningitis, or tumor (syphiloma); but arteritis must now be considered as frequent.

\* Syphilis of the Nervous System, New York Medical Journal, 1870, November.

† Lancereaux, *Traité de la syphilis.* Paris 1874 (see pp. 307-9).

The first chapter of Heubner's monograph is devoted to a history of syphilitic disease of the nervous centres, and of syphilitic disease of the arteries of those centres. To Astruc (1740) he gives the credit of first having called attention to interference with the circulation in the cerebral arteries, as a result of syphilis. It was not until many years later that this line of investigation was pursued, chiefly in consequence of Virchow's great studies upon thrombosis and embolism (1846). Since that year a number of observers have published cases of syphilitic arteritis; Dittrich (1849), Gildermeester, Gjör, Dixon, Bristowe (1859), Steenberg, Graefe, Griesinger (1860), Passavant, Wilks (1863), Jacksch (1864), Lancereaux (work on syphilis, ed. 1868), after 1869 Jackson, Peacock, Ramskill, Allbutt, Tait, Moxon and others, the author (1871 and 1872), Braus, Lancereaux (1873).

The introduction to the second chapter is devoted to statistics of the lesions found in cases of syphilis, accompanied by symptoms of disease of the nervous system. The author has gone to all possible sources, and obtained records of 164 autopsies.

In 68 cases there were syphilitic neoplasms (syphilomata) with or without softening of the brain substance (no mention of disease of blood-vessels).

In 36 cases meningitis, or encephalitis, or atrophy of the brain; (in only two of these cases is the healthy state of the blood vessels expressly stated).

In 16 cases no lesions existed.

In 44 cases there were, in addition to syphilomata, or inflammation, or without these, alterations of blood vessels—thickening of their walls, obliteration, thrombosis, etc.

The remainder of this chapter (pp. 17 to 123) is devoted to the relation in more or less extended form of all recorded cases of syphilitic lesions of the cerebral arteries, 50 in all. Cases 33 to 35, inclusive, are from the author's first contribution in the *Archiv der Heilkunde*, 1870, p. 280, *et seq.* The new observations added by the author are numbers 45, 46, 47, which are related at full length, their symptomatology being completely given, and the pathological conditions minutely described. The morbid gross and minute anatomy of the arteries, is described in the most complete manner, and illustrated by four lithographic plates. Cases 48, 49, 50, are from the practice of Dr. G. Merkel, in Nürnberg, pathological preparations from which were examined by the author.

The general semeiology of cases of encephalic arteritis with or without meningitis, may be best illustrated by quoting the summaries of Heubner's own cases, numbers 45, 46, 47.

Case 45, male,  $\text{\textit{A}Et.}$  30, who acquired syphilis in his twentieth year. This was quickly followed by secondary symptoms, several years later ulceration of the skin. Headache began to show itself seven

years after infection. Nine years after infection apoplectic attacks with stupor, delirium, convulsions of short duration, followed in a few weeks by blindness of left eye, which diminished in the course of six months. At that time hemiplegic symptoms appeared; weakness of sight in right eye, progressing to blindness in four weeks; the left eye again getting worse. In nine months after beginning of head-symptoms, double blindness, paresis of left side of body, emaciation of right arm; in ten months, delirium and stupor lasting several weeks; improvement under inunction of mercury, a gummy tumor disappearing and ulcers of the skin healing. In twelve months after beginning of head-trouble frequent epileptoid seizures; in sixteenth and eighteenth months periods of stupor; received improvement from use of mercurials, a period of relatively good health in the nineteenth and twentieth months; followed in the twenty-first by an attack of dizziness, stupor, coma, ending in death after a few days.

Autopsy: Syphilitic new-formations upon the anterior part of the pons Varolii, between the corpora mammillaria and the chiasma with sclerosis of the left optic nerve, and compression of both nerves of the third pair; and with extension of the product to the inferior part of the first frontal gyrus of the left side, and to parts of the right hemisphere. Secondary softening in the pons, and in the left anterior lobe. The basilar artery and its left branch as well as the left carotid artery and all of its first branches are involved in the new formation. The lumen of these arteries is diminished by a proliferation of their membrana intima, which extends outward from the point of union of the vessels to the new-formation; many small peripheral arterial branches are obliterated. The skull bears syphilitic markings.

Case 46, male,  $\text{\textit{A\textit{E}t. 24 years}}$ . In May, 1872, had a chancre which healed in five days (had a chancre [?] also some four and a half years previously) followed by exanthema and headache. About one month after appearance of exanthema while the patient was still confined to his room, had an apoplectic fall without loss of consciousness. At that time palsy of muscles of eyes, together with a state of insomnia, temporary aphasia, vertigo, headache, and intervals of freedom from symptoms. In another month renewed and almost continuous insomnia, intermitting delirium, involuntary evacuations, cramp-like jerking of the lower extremities; contracture at first of those of the left side, and later of those of the right; deep coma; death two and a half months after first head-symptoms.

Autopsy: Syphilitic tumor of the left oculo-motorius nerve; adherence between it and the posterior communicating artery of the left side; thickening of this vessel; extension of the morbid process to numerous other arteries, producing extreme diminution of their calibre. Syphilitic disease of the testis.

Case 47, male, *Æt.* 22 years. Chancre followed by recurring exanthemata. In twenty-second year another chancre, succeeded by more severe skin-symptoms. Soon afterward, between second and third years after the first infection, had an attack of palsy of right arm, together with delirium, soporose state, and involuntary evacuations. This attack passed away leaving only a little paresis. Four years later, six months after a recurrence of skin symptoms, had a second attack, characterized by loss of consciousness, marked palsy of the right side, in which afterward appeared contracture. The leg improved somewhat; renewed incontinence of urine, and faeces. Three months later diarrhoea, emaciation, anasarca albuminaria; death by exhaustion in the course of six weeks.

Autopsy: Syphilitic disease of the skin, skull, liver, testis, amyloid degeneration of the liver, spleen, kidneys, intestines, cheesy degeneration of the mesenteric glands, widely-spread thickening of a peculiar form affecting many cerebral arteries; yellow softening (with partial sclerosis) of the left corpus striatum (and its extra ventricular part); moderate cerebral hypertrophy; secondary degeneration in base and spinal cord.

The above summaries exhibit sufficiently well the very polymorphic symptomatology of syphilitic affections of the nervous centres; a polymorphism which has attracted the attention of all modern clinicians. The gross pathological anatomy is very well described in these cases. The author reports the morbid histology of the various parts affected very minutely, dwelling with emphasis upon the changes in the coats of arteries.

Chapter III is devoted to (*a*) a new study of the normal histology of the cerebral arteries, and (*b*) an exhaustive and most able discussion of the nature, seat, mode of origin, and progress of the syphilitic arteritis. As we take the greatest interest in the clinical parts of the work, it will suffice if a very short *r  sum  * of the second part of this chapter be given. The lesion is essentially an endarteritis, characterized in its early stage by a deposit of round cells, chiefly migrated from blood-vessels, in the *membrana intima*, between the endothelial layers and the *membrana fenestrata*. These cells form masses or swellings, on which the endothelium lies; and it is this neoplasm which diminishes the calibre of the vessel. At a later stage of the process, or when the artery is irritated by an adjacent syphiloma, the same round cells are found in the muscular coat. Later there is a proliferation of the endothelium. The new formation is apt to extend in one direction, or even to form well-defined masses, small tumors, which infringe upon the calibre of the vessel. In the neighborhood of the thickening the vessel is apt to present dilatations produced by systolic force. At the constricted part a thrombus may be formed. These elements of the new-formation do not undergo fatty involution as do the round cells of other syphil-

itic deposits. The muscular elements of the artery opposite or near the lesion undergo atrophy. A spontaneous cure by shrinking may occur, but brings about closure of the vessel. In short, the formation is made up of embryonic cells chiefly (migrated leucocytes?). It appears in many arteries, and affects more or less limited regions in them. The author goes on to compare these peculiar alterations with those found in the well-known atheromatous process.

The fourth chapter is a remarkable study, in good part original, of the peculiarities in the cerebral circulation; and gives valuable indications of the arterial supply of various districts of the brain; superficial and deep, many of the symptoms observed in the recorded cases are accurately explicable by means of the data contained in this chapter.

The fifth chapter treats of the etiology, symptomatology (in general) and therapy of the affection. In regard to the first point, it is important to note that in twelve of the recorded cases the symptoms of disease of the nervous system appeared at the following periods after infection: In two cases, three years; in one case, four years; in three cases, five years; in one case, twelve years; in one case, twenty years; in one case, six months; although here the symptoms may have been produced by meningeal lesion. With regard to treatment (and prognosis) Dr. Heubner states that he has seen several severe cases of brain-syphilis (most probably due to endarteritis) recover completely under treatment. He relies on the iodide of potassium, given in what he calls the "very large" doses of from thirty to one hundred and fifty grains per diem.

Mercury should also be employed to slight saturation, applied by inunction, with or without severe diet (*Hunger-Kur*). In certain cases stimulants, and nutritious food are indicated. General blood-letting is dangerous; local evacuation is of use for the relief of head-pain, etc. The palsies remaining are to be treated by electricity, etc.

The author has not yet heard of the American practice of giving the iodide of potassium in the really effectual doses of two, four, six and even eight drachms a day; recent journals would seem to indicate that this practice, so successful with us, has been introduced into Great Britain, and we hope it will attract the attention of Continental physicians. Four excellent lithographic plates illustrate the work, which we consider as a standard monograph. [E. C. S.]

#### BOOKS AND PAMPHLETS RECEIVED.

Syphilitic lesions of the Osseous System in infants and young children. By R. W. TAYLOR, M. D., Surgeon to the New York Dispensary, etc. Wm. Wood & Co., 1875. 8vo. pp. 179.

A series of American Clinical Lectures. Edited by E. C. SEGUIN, M. D. No. 1, On Diseases of the Hip Joint, by LEWIS A. SAYRE, M. D.; No. 2, Acute Rheumatism in Infancy and Childhood, by

A. JACOBI, M. D.; No. 3, *Pneumo-Thorax*, by AUSTIN FLINT, Sr., M. D. New York: G. P. Putnam's Sons, 1875.

Nomenclature of Diseases, for the United States Marine-Hospital Service. By JOHN M. WOODWORTH, M. D. Washington, 1874.

Affections of the Sebaceous Glands. By EDWARD WIGGLESWORTH, Jr., M. D. Reprinted from *The Boston Medical and Surgical Journal*, 1875.

Case of painful Neuroma of the Skin, with exsection of the brachial plexus of nerves. By Drs. L. A. DUHRING and F. F. MAURY. Reprinted from the *Am. Jour. Med. Sci.*, Oct., 1873, and July, 1874.

Pruritus hiemalis, an undescribed form of pruritus. By L. A. DUHRING. Reprinted from the *Phil. Med. Times*, 1874.

On a disease of the skin produced by *Acarus folliculorum*. By EDWARD SPARKES. From Vol. LVII of the *Med. Chir. Trans.* London, 1874.

Clinical observations on certain Diseases of the Skin. By DYCE DUCKWORTH. London, 1874. Reprinted from *St. Bartholomew's Hosp. Reports*.

Third Annual Report of the Dispensary for Skin Diseases. Boston, 1875.

Third Annual Report of the Dispensary for Skin Diseases. Philadelphia, 1874.

First, second and third Reports of the Foochow Med. Missionary Hospital. Foochow, China, 1872, 1873 and 1874.

Report of the Vaccine Department of the New York Dispensary, for 1874. By FRANK P. FOSTER, M. D., Director of Vaccine Department.

Erysipelas, its etiology, etc. By F. L. SATTERLEE. Reprinted from the *N. Y. Medical Journal*, 1874.

The Etiology of Congenital Syphilis, histologically considered. By J. E. ATKINSON. Reprinted from the *N. Y. Medical Journal*, 1875.

The Treatment of Secondary Syphilis. By J. L. MILTON. Reprinted from the *Edinburgh Medical Journal*, 1875.

What effect does Syphilis have upon the duration of life. By F. R. STURGIS, M. D. Reprinted from the *N. Y. Medical Record*, 1874.

A case of reflex neuralgia, associated with urethral contractions and a rare form of urinary sinus. By F. N. OTIS, M. D. Reprinted from the *N. Y. Medical Journal*, 1875.

Urethrotomy, external and internal combined, in case of multiple and difficult stricture; with remarks on the urethral calibre. By F. N. OTIS, M. D. Reprinted from the *N. Y. Medical Journal*, 1874.

## Correspondence and Miscellanies.

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SINCE the publication of our last issue, a circular has been received announcing the cessation of the AMERICAN JOURNAL OF SYPHILOGRAPHY AND DERMATOLOGY, at the expiration of its fifth year of publication. During the first two or three years of its appearance it was ably supported by original contributions from our best writers and authorities, but latterly there has been an absolute dearth of original matter, the pages being entirely occupied by reprints and translations. The editor, giving reasons for its cessation, in the circular referred to, says: "We regret to *confess* that paltry purposes deprived us of much domestic assistance." It is indeed unfortunate for one's purposes to be so paltry in the publication of a scientific journal that those to whom he naturally looks for support should fail to give it; it is well, however, to confess, even when too late to mend the error.

It is with heartfelt gratitude that we return thanks to our collaborators for their very thorough and scientific performance of the work on the Digest of Literature. This epitome, we believe, excels any that has ever been presented to the profession, and with the completion of the year, will present an amount of collated material otherwise unattainable to our readers, even with their utmost exertions.

We proffer also our acknowledgments to those who have so kindly furnished us with the *twenty-four original* and clinical communications in the three issues of the year, and also for the very encouraging and commendatory notices of the press. Likewise for the many kind letters from all sides, which we trust to answer individually as time and strength permit.

We look yet to our collaborators and to the profession to make the ARCHIVES OF DERMATOLOGY worthy its name, and to vindicate the claim to an American School of Dermatology.

"Brevity, indeed, upon some occasions, is a real excellence."  
—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

JULY, 1875.

## Original Communications.

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### FOUR CASES OF SCLERODERMA.

BY JAMES C. WHITE, M. D., BOSTON.

*Professor of Dermatology in Harvard University.*

SCLERODERMA has attracted the attention of dermatologists so much in the past few years, and so good description of the disease are to be found in their writings, that nothing need be said in introduction concerning the following cases. I have been led to report them because the affection is a very rare one and its nature needs further investigation, and because the additional data they furnish are in some respects novel.

*Case 1.*—E. M. G., the patient, was first seen by me in June, 1874. She was a girl 22 years old, and her health had always been good until two years previously, when it gradually failed without apparent cause, or more definite symptoms than a little indigestion. She continued at her employment in the chemical chamber of a photographer for six months, when for want of strength and ability to move her limbs freely she gave up work, and has done none since. It was at this latter period that her attention was first drawn to the peculiar change in her condition. She noticed that her hands and knees were of a darker color than the rest of her skin, that she could not use her fingers well, and that her knees were so stiff that she could not easily raise herself to a standing position when sitting. From this time, for a year or little more, the changes in her skin very gradually progressed to the state in which I first saw her, but there had been no marked advance in them for the three or four months immediately preceding my examination.

The face presented a dark appearance over its lateral regions, and as the patient was a blonde, the melasma was very noticeable. But what especially attracted attention was the placid, immovable look she wore during conversation or laughter, as if she had never learned to use her facial muscles. She could wrinkle her forehead slightly, and could close her eyelids without much difficulty. The movement of the mouth and jaws, however, were considerably impaired, and she couldn't whistle, although she "used to like to." The whole integument of the face felt hard and thickened, the induration being greatest over the forehead and sides. The ears were somewhat stiffened. The neck and bust were very dark colored, and the whole front upper chest felt hide-bound and was marked by numerous small white streaks, the pigment in these linear districts in reality remaining in normal quantity, but by contrast giving the appearance of parallel lines of leucoderma. The breasts were unaffected. The arms were very dark colored throughout, and below the elbows the skin was very dense. The movements of the elbow-joint were considerably impeded. The hands were very dark, resembling those of a mulatto, and running along the backs of the fingers were seen several longitudinal white streaks like those upon the chest. It was seen here more plainly than in the latter region, that these lines were made up of white points corresponding to the mouths of the follicles and sweat glands, around which the melasma had failed to develop itself. The skin of the hands was very firm, so that they felt like those of a statue, and only a very slight motion of the phalangeal joints was possible. The thighs were very dark colored, but with the exception of the region of the knees, around which the skin was considerably thickened and hardened, the integument of the lower extremities was not much changed in consistence. The toes were scarcely at all affected.

The functions of the skin appeared unaltered, although in the beginning she thought the perspiration was for a time lessened over the whole surface. The cutaneous temperature was possibly a little lowered, but not materially so, and the sensibility of the skin to touch and pain was unimpaired. There had been but little change in her weight, and the state of her general health was satisfactory in all respects, and had it not been for her hide-bound condition, especially of the upper extremities, she would have been able to work.

Four months after the first examination the patient was again seen. She had been in good health, and there had been apparently no advance in the progress of the disease.

In April, 1875, I saw her again. She had been suffering greatly from indigestion, so that she had lost nearly twenty pounds of flesh, but little alteration in the condition of the skin was noticeable.

She had had "sores" upon the knuckles and tips of the fingers, suppurating and lasting several weeks, the result of bruises and knocks, she said. The marks of these were plainly visible. The color of the hands was even darker than before, and several leuodermic patches of considerable size were for the first time seen upon the backs in strong contrast with the general melasma of the parts. Her condition is well expressed by her remark at this time, that persons called at her house and asked to see "the petrified girl."

*Case 2.*—Mrs. C. B., æt. 38. This patient was seen in November, 1873. She was born in Ireland, and had always been well until the previous January, when, after taking cold, her catamenia suddenly ceased and never reappeared. Soon after this she felt prickling and twitching sensations in her face and arms, with "drawing feelings," and noticed that the skin of these parts was changing color and becoming hard. At the same time she began to lose flesh and spirits. In the following May she was married for the first time. Her general ill health and the affection of the integument had gradually progressed to the condition presented at the date of examination.

At that time the patient was considerably emaciated and reduced in strength. The skin of the whole face was very firm, so that the movements of all the facial muscles were made with difficulty. Its color was generally dusky. She had difficulty in eating on account of the induration of the integument about the mouth, and her tongue seemed larger to her than formerly, although it was not changed appreciably to touch. The face presented over the upper parts a fine papular, follicular inflammation, which had preceded, and had not been modified by the development of the sclerous condition. There was also an increased sebaceous flux over the face, so that the combination of this glossiness with the general melasmic hue, and red tints of the follicular hyperæmia gave to the immobile and stony countenance a most peculiar aspect. The arms from the elbow downward were of a dusky color, the pigment deposit growing deeper to the finger ends. A similar progression in intensity downward marked the development of the hardening of the integument over the same parts, the skin of the hands, especially the fingers, being seemingly converted into sole leather, so that motion in them was very difficult. The skin of the upper portion of the trunk was deeply colored, and the respiratory movements of the chest were considerably impeded by the inelastic induration which had taken place in it. Upon the lower extremities only a slight degree of hardening was noticed, and there was but little difficulty in walking.

The hands felt cold to the patient at times, but there was no-

where any great change in the temperature of the skin or in its sensibility. The sclerosis was decidedly more marked upon the right arm and leg than upon the opposite half of the body.

The patient was seen several times subsequently during a period of six months, but little change in the condition of the skin was noticed. Her general health, however, deteriorated, and symptoms of pulmonary disease were making themselves manifest. Of her condition during the past year, or if she be still alive, I have no information, as she lived in another city.

*Case 3.*—C. E. This patient was a woman 54 years old, and a native of Ireland. Her health had been generally good until two months before I saw her (December, 1874). At that time she had had a severe and sudden attack of pain in the region of the left axilla, which was followed in a few hours by swelling of the parts. How long these symptoms lasted it was impossible to learn positively, but probably a few days. Very soon afterward she noticed a change in the left hand, which continued to increase until she consulted me concerning it.

A careful examination of the axillary and neighboring regions failed to discover any tissue change there. The left hand, however, presented this very peculiar condition. The skin of the ulnar half was marked by irregularly shaped, faint melasmic stains upon the dorsal surface, and was very dense and firm. Upon the third and fourth fingers the change was still more apparent. They felt as if made of wood, and could only be flexed about one-half the usual extent. A very slight induration of the skin about the wrist upon its ulnar side was apparent, but further than this no change was detected. The other fingers and thumb were in their normal state.

*Case 4.*—T. G. is a Scotchman, 42 years old. He lived in Glasgow until the age of 23, when he enlisted in the marine artillery, and served in the Baltic two years during the Russian war. He returned to Scotland, but eighteen months subsequently came to this country, and has worked in a neighboring town as a stone mason, with the exception of one year's service in our cavalry during the war of the rebellion, at which time he had "chills and fever." This was his only sickness until the beginning of his present trouble. I first saw him in February, 1874.

Eighteen months previously he noticed that the skin over large portions of his body was covered with small white elevations, and looked, he says, like that of a plucked goose. These prominences soon disappeared, he thinks, but the skin afterward continued to feel tight and bound. Six months afterward his forehead began to assume its present appearance, and severe pains were felt extending from the elbows to the fingers, which lasted two months and

ceased, leaving the skin of the hands and forearms tight. Six months before I saw him, the integument from the right shoulder to the top of the head upon the same side became inflamed and covered with blisters. This attack lasted three weeks, and was called by the family erysipelas. A physician who met him said he looked as if he had been poisoned by dogwood (*Rhus*). During the last six months before I saw him, he thought there had been but little change in the state of the skin. This was as particular a history of his previous condition as he could give.

On inspection the face seemed, at first, to be marked by an extraordinary development of the frontal protuberances, by a very broad nose, and to be very strongly pitted over its upper part by smallpox. Its general hue was slightly redder, and it was more glossy looking than was natural. The eyes appeared to be only half open, and as if hidden by the overhanging prominences above. On closer examination the skin of the forehead was found to be intensely hard and greatly thickened, and to be marked by depressions varying in size from a pin's head to a pea. Over the frontal sinuses were broad and dense projections, and between them, running down to the nose, a rigid, elevated, semi-cylindrical band of cicatricial hardness, the surface of which was marked by the same peculiar depressions. The nose in its upper half broadened out and merged itself into the cheeks, the skin of the parts being of an almost bony hardness. From the alae there radiated to the lower cheeks lesser bands of the same cicatricial hardness, which were not elevated above the general surface. The skin surrounding the mouth was also very dense. He could not move his face to laugh, and he had not been able to whistle or play the flute for a long time. He had some difficulty even in getting his food into his mouth. The ears were very stiff and large, and were everywhere marked by small and large prominences of intense hardness. Surrounding them in all directions, even upon the scalp nearly to the vertex, there were seen still more exaggerated and abruptly defined elevations of cartilaginous feel and white color, which formed with the interspersed depressions of a deeper color a very striking contrast. The trunk was quite generally covered on its front and back surfaces with thickly clustered papular elevations, varying in size from a pin's head to a small pea, which were white, and looked like over-filled sebaceous glands. They were of intense hardness, however, to the touch, and cut like gristle. On the upper chest these elevations were arranged in parallel rows, as if occupying the seat of excoriations produced by the nails in scratching. The skin of the arms, beginning half way above the elbows, was of increased hardness, and more dusky in color than elsewhere. Below the elbows the induration increased progressively to the finger-tips, the hands being very hard as if encased in sole leather, but the sur-

face of the upper extremities was perfectly smooth and free from the elevations and depressions so conspicuous elsewhere. Scarcely any movement of the fingers was possible, and work had been given up eight months previously from inability to hold the drill. The color of the hands was paler than natural, excepting between the fingers, where a dusky hue was noticeable. The thighs showed some general hardening of the skin, and at the upper part an occasional group of small papular and linear ridge-like elevations similar to those upon the trunk.

The sensibility of the skin was in no way blunted, and its temperature was nowhere affected except upon the hands. These felt cold to him, and were somewhat over-sensitive on pressure. They did not perspire, moreover, to any appreciable amount, although the action of the sweat-glands elsewhere was unaltered. He felt generally hide-bound, and the skin seemed more sensitive to cold than formerly. His general health was very good, although he did "not feel quite so strong as he used to." His functions were all in good order, and had it not been for the immobility of his arms and hands he could have worked nearly as well as ever.

In the beginning of 1875, just one year after the above description was taken, he was again examined. His health had remained uniformly good. There was but little change in the condition of the skin; possibly the appearances were a little more pronounced, certainly there had been no retrogression. His only complaint was of an itching about the genitals, and a few minute excoriations from scratching were seen about these parts. Upon the lower abdomen and the upper femoral regions it was noticed that small, papular, firm and colorless elevations were beginning to show themselves arranged in parallel rows, together with prominent linear ridges of the same dense consistence. The latter were much more marked when the skin was forcibly stretched, and their position and arrangement reminded one of the marks of linear atrophy in women, except that here we had elevations instead of depressions.

In April the patient was again seen. He was recovering from an attack of pneumonia, which had left him considerably reduced in flesh and strength, but had been followed by no marked change in the condition of the skin. A portion of one of the nodular masses behind the ear was removed, and its structure examined by the microscope. The epidermal layers were normal in appearance; possibly a little thickened. The papillæ were somewhat less prominent than natural, and they, as well as the rest of the integument below, as far as the incision extended, were converted into a dense structure consisting of a firm network of fibrous tissue. The elastic fibres were very numerous. But few cell elements were seen, and no glandular structures were seen in the sections examined. Dr. Fitz, who also examined the specimen, found "no evi-

dence of enlarged lymphatics," and likened the tissue unto that of elephantiasis arabum.

The first two of the above cases may be regarded as typical in their course and appearances, while the last deviates so widely, in some respects, from cases hitherto recorded, that I hesitate to class it among them, and do so, partly, because its position elsewhere among recognized affections of the skin would be still more inappropriate.

In all of them we fail to detect any exciting causes of the development of the disease, and the constant good health, prior to the local affection, is especially noticeable. Three of the patients were women; one a man. The ages at which the diseases began were respectively 21, 37, 54 and 41. Two were of Irish descent, one was Scotch, and one an American. The most remarkable feature common to all, in addition to the sclerosis of the integument—the one essential element of the disease—was the pigment change expressed by melasma, and, to some slight degree, by leucoderma of the parts affected. The functions of the skin were but slightly modified, the sweat glands acting with a little irregularity in some cases, while there was a slight degree of seborrhœa in two and an acne in another of them, upon the parts affected. In all four, the upper parts of the body were most seriously affected, the sclerosis being most highly developed upon the fingers. A want of lateral symmetry was shown in cases II. and III., the affection being most pronounced upon the right half in the former, whilst in the latter it was not only confined to the left hand but to the ulnar side of this. In connection with the opinion founded on the pathological anatomy of the disease—that it is primarily an affection of the lymph system, and that the new formation of fibrous tissue of which it essentially consists is analogous to the process in elephantiasis arabum—it is interesting to note the occurrence of an inflammatory process of the skin in the last two cases. In number III it is fair to conclude that this attack, which immediately preceded the sclerosis, was, in some direct way, connected with its development; but in the last case the inflammation of the integument, although it may have been of an erysipelatous character, did not come on until a year after the beginning of the general affection, and was confined to a small part of the affected regions, so that it

can hardly be regarded as possessing any more intimate connection with the disease than that of an accidental occurrence. In fact, the whole clinical history of scleroderma indicates that, although closely allied to elephantiasis Arabum in its anatomy, it is wholly unlike it in etiology.

I can nowhere find mention of a case like this last in the descriptions of scleroderma or other affections of the skin. Dr. Duhring and Dr. Wigglesworth examined it with me during the past winter, but neither of them, I believe, had ever seen its like. It is unlike scleroderma in the marked depressions and elevations which form its surface appearances, although Kaposi describes prominent, cord-like indurations in two cases, which suggest to him the identity of the disease with Addison's keloid. The pointed nodules about the ears, the tubercular prominences about the neck, and the broad and elevated bands or ridges on the forehead, taken by themselves remind one, in fact, most strongly of some forms of keloid and hypertrophied scars. The pigment alterations, moreover, were less developed than ordinarily in scleroderma. In its seat, however, its course, and the nature of the tissue changes which determine its true character, the affection is identical with scleroderma, and the condition of the skin of the forearms and hands differed in no way from the ordinary manifestations of the disease. The case might properly be called scleroderma, with an exceptional tendency to exuberant outgrowth.

BOSTON, May, 1875.

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### PITYRIASIS RUBRA.

BY GEO. HENRY FOX, M. D.

*Surgeon to the New York Dispensary, Department of Venereal and Skin Diseases, and to the North-Western Dispensary, Department of Skin Diseases.*

**T**HREE is no affection of the skin so differently described by different writers as *pityriasis rubra*. Reading the clinical descriptions found in dermatological text-books, it is easy to perceive that widely differing affections have been described under the same name, and, even when it is evident that the writers are speaking of the same affection, we are struck by the singular dis-

crepancy of their statements. This, doubtless, results from the circumstance that true *pityriasis rubra universalis* is of such rare occurrence, that it is almost impossible to say whether, in any given instance, the disease is running a typical or an anomalous course. Hebra,\* in his vast experience, has seen but fourteen cases. Neumann † speaks of having observed two cases. Erasmus Wilson ‡ has published three cases. Tilbury Fox § in his book refers to four cases, while McCall Anderson || reports seven cases as occurring among 11,000 patients affected by skin disease. Other eminent writers appear to have never seen this disease at all, for the affections which they describe under the head of *pityriasis rubra* are surely of quite a different nature. The writer has had the opportunity of seeing three cases of this disease, one in the general hospital of Vienna, one in the University College hospital of London, and the case about to be given. These three cases presented, in the main, the same clinical appearances.

In glancing at the history of this disease, we find that the name *pityriasis rubra* is first used by Bateman. He applies it, however, to an affection "occurring in patches, with a dry surface and troublesome itching," in short, to *eczema squamosum*, or possibly to that branny condition of the skin which is secondary to *erythema*. Alibert does not use the term. Rayer,\*\* under the title of *pityriasis général*, fully describes an affection which in many, if not all, essential points, coincides perfectly with the disease in question. To Rayer, then, belongs the merit of having first described the affection, although the credit is usually awarded to Devergie †† who first pointed out its acute and chronic stages, and made a clear differential diagnosis of the disease.

Hebra and Tilbury Fox give, perhaps, the most satisfactory description of the affection, although their experience and views

\* Hebra and Kaposi, *Lehrbuch der Hautkrankheiten*, II Auflage, 1874.

† Neumann, " " " III " 1873.

‡ E. Wilson, *Lectures on Eczema*, 1870.

§ T. Fox, *Skin Diseases*, 3d ed., 1873.

|| Anderson, *treatment of the diseases of the skin*, 1873.

\*\* Rayer, *Traité des Maladies de la peau*, II, 1835.

†† Devergie, " " " 1854.

do not fully coincide. As for the descriptions of the majority of recent dermatological writers, they all bear a strong resemblance to the one originally given by Bateman, and are not at all applicable to true *pityriasis rubra*.\*

As an addition to our knowledge of the affection, I give the history and a few notes of the following case:

Margaret M., æt 50, Irish, came to the North-Western Dispensary on April 8, 1875. Her skin from head to foot appeared reddened and wrinkled, though almost hidden from view by numerous thin and whitish flakes of exfoliated epidermis. These flakes were of variable size and form, though mostly about an inch square. Their edges were curled, and but a small portion of the under surface was adherent. They were friable and easily peeled or rubbed off in quantities. Every morning, according to patient, a double handful of scales could be taken out of her bed. After removal of scales, the skin would feel less sore, but a sensation of chilliness would be experienced. The redness of the skin could be lessened by pressure, but there seemed to be no active hyperæmia. There was slight, if any, thickening, although a general tumefaction of the skin existed which apparently resulted from a serous infiltration of the cellular tissue. The face was but slightly affected, only a fine desquamation being noticeable, which was absent upon the nose and cheeks. The palms and soles were free from scales. Upon the flexor surfaces of the joints the scales were mostly rubbed off, leaving an irritable appearance of the skin with well-marked creases, and a certain degree of moisture. This moisture, observable upon other portions of the body after removal of the scales, was not like the gluey exudation of *eczema* from a surface entirely deprived of epidermis, but was merely a hypersecretion of the perspiratory glands. There was but slight itching of the skin, and that only at times. There was neither redness of the pharynx, nor injection of the conjunctiva. The patient, according to her own statement, had always been strong and healthy. At date of examination her general health seemed good. In spite of intemperate habits, her tongue was clean, appetite very good, digestion perfect, and bowels regular. There was no history of former skin eruptions, nor of any significant disease, and the only symptom complained of was a swelling of the feet upon standing. About two and a half years ago her menses stopped. Having previously lost her husband, she was, for some time, subjected to hard work and constant worry, which may have been a cause of the disease.

\* Since writing the above I have read the interesting brochure of Percheron. "Etude sur la dermatite exfoliatrice généralisée," Paris, 1875, and would refer the reader to his complete and careful description of the affection.

The present eruption began two years ago on her wrists, with circumscribed redness and desquamation. In a few months patches appeared upon the body and extremities which gradually coalesced. Last spring the eruption became rapidly worse; hardly leaving a sound piece of skin. During the past winter her hair had fallen out considerably, and when first seen she was in a worse condition than ever before. She had never been under medical treatment, but had derived comfort from rubbing lard upon the skin. The treatment adopted consisted in the internal administration of drachm doses of acetate of potassium three times a day, with the external inunction of olive oil. In a week the patient returned, and, to my great surprise, manifested a very marked improvement, and somewhat to my disappointment, I might frankly add, as I had intended upon her second visit to have a photograph of the case taken. The exfoliated epidermis had been removed, and the tendency to the reformation of flakes was slight. The hyperæmia was considerably lessened, the skin was far more supple, and the extremities less swollen. Since then cod liver oil has been used internally and externally, and she has improved still more. At the present time she remains temporarily well, with no treatment whatever.

In connection with the report of this case, I would briefly call attention to the pathological nature and clinical features of this rare and interesting affection.

Erasmus Wilson applies to it the name of *dermatitis exfoliativa* but the inflammatory nature of the affection is somewhat doubtful. There is a notable absence of that febrile reaction which such an extensive inflammation would necessarily involve, and the usual products of chronic inflammation are never observed.

That it is not an *eczema* is tolerably evident. At no stage does it present a punctated, papular or vesicular form. There is never any sero-purulent or gummy exudation. There is no intense pruritus with resulting excoriations. There is no induration, and consequently no formation of fissures. There are no essential changes in the fibro-cellular tissue, and post-mortem examination of the skin is said to reveal no abnormal conditions. The fact that the flexures of the joints may become the seat of a *secondary eczema*, proves nothing as to a connection between the two affections.

That it is an affection primarily dependent upon disordered

action of the vaso-motor nerves is far more probable. Its identity with *eczema* or *psoriasis* is by no means as clear as its association with *pemphigus foliaceus*, to which affection it bears, in some respects, a strong clinical likeness. The bullae, though always present, do not constitute the primary lesion of the latter disease; and in *pityriasis rubra*, although they are not usually observed, they may be present, and according to Devergie the disease may undergo a transformation into *pemphigus*. In the extensive exfoliation of cuticle, in the serous exudation which, in the one case, imparts to the skin a peculiar moisture, and, in the other, lifts the epidermis into bullae, in the marasmus of the latter stage and in the slow recovery, if not the fatal termination of either disease, we observe a striking similarity, and I venture to say that a deeper insight into the etiology and nature of skin disease will yet reveal an intimate connection between these two affections.

160 WEST 34TH STREET, NEW YORK.

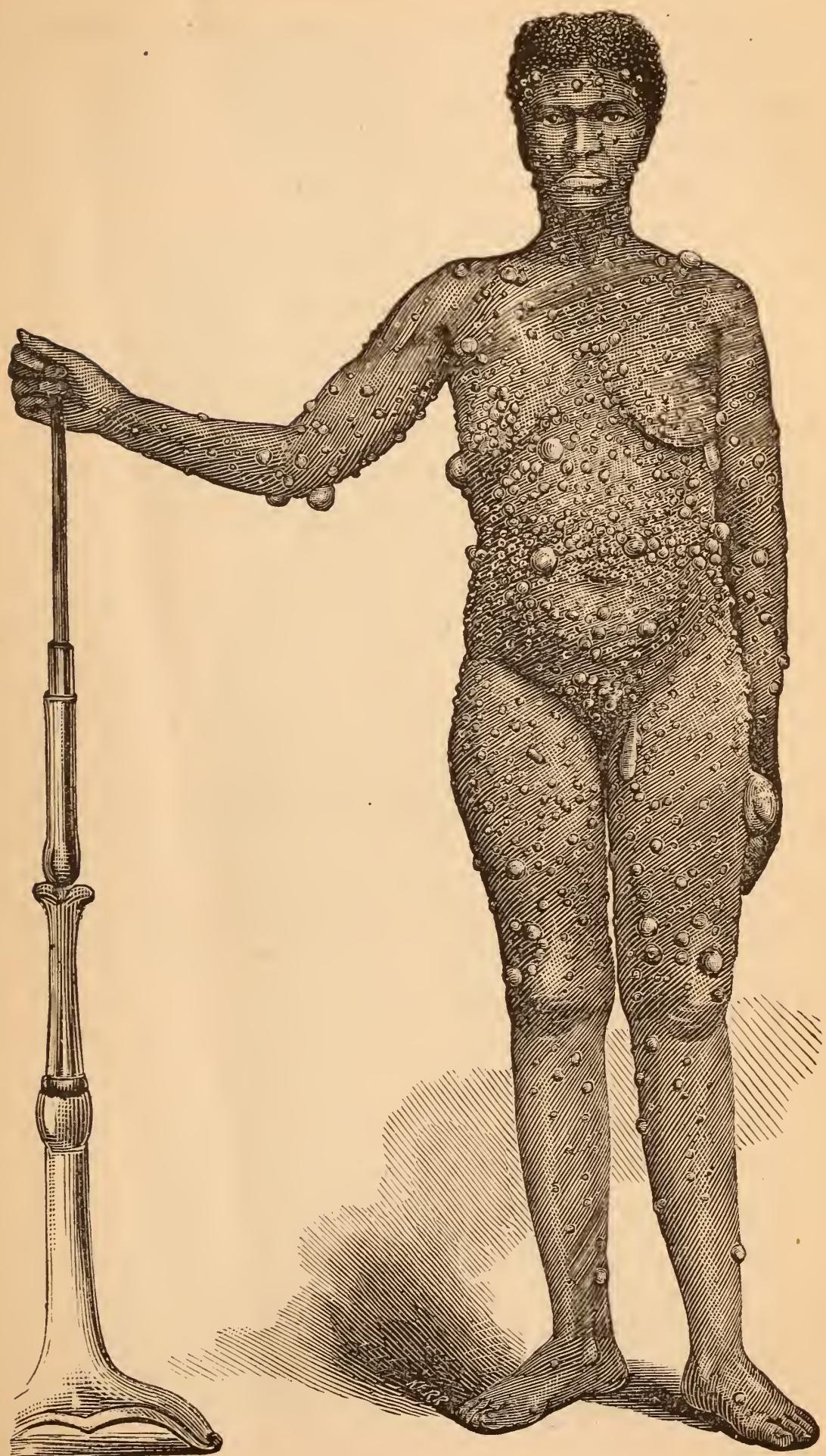
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## A CASE OF MOLLUSCUM SIMPLEX WITH ILLUSTRATIONS.

BY JOHN A. OCTERLONY, M. D.

*Professor of Materia Medica, Therapeutics and Clinical Medicine in the Louisville Medical College, and in the Kentucky School of Medicine, &c., &c.*

W<sup>R</sup>ITERS on Dermatology, and observers of widest experience in this specialty, very generally agree that well-marked cases of molluscum simplex are far from common. However, it is not only on account of the rarity of the disease I am induced to publish this case, but because it presented the most exaggerated developments of molluscum simplex I have ever seen. Tilbury Fox quotes a case recorded by Prof. Ebert, of a man who had 107 tumors. In the last edition of his work on diseases of the skin, he mentioned another case which he saw at Prof. Von Hebra's clinic in Vienna. In this the whole body was covered by the tumors which were of all sizes. The wood-cut illustrating



this article certainly displays a very well-marked case, but I believe in the instance here reported by me the tumors were more numerous than in either of the cases mentioned above, and were not only of all sizes, but furnished specimens of all varieties of shapes that have ever been described.

The patient, *Martha Clay*, was a negro woman, a widow, and by occupation a cook. She believed herself to be about 60 years of age, had been twice married, and had borne eleven children. Her health had been remarkably good through life, and she could not recollect having ever been seriously sick. She had known both her parents and grandparents, but all of them were entirely free from this affection. Her children have also enjoyed the same immunity except the youngest, who, at the time she first came under my observation, was 22 years of age. A year or two had passed since she had last seen him, but at that time the tumors were not so numerous on his as on her own body.

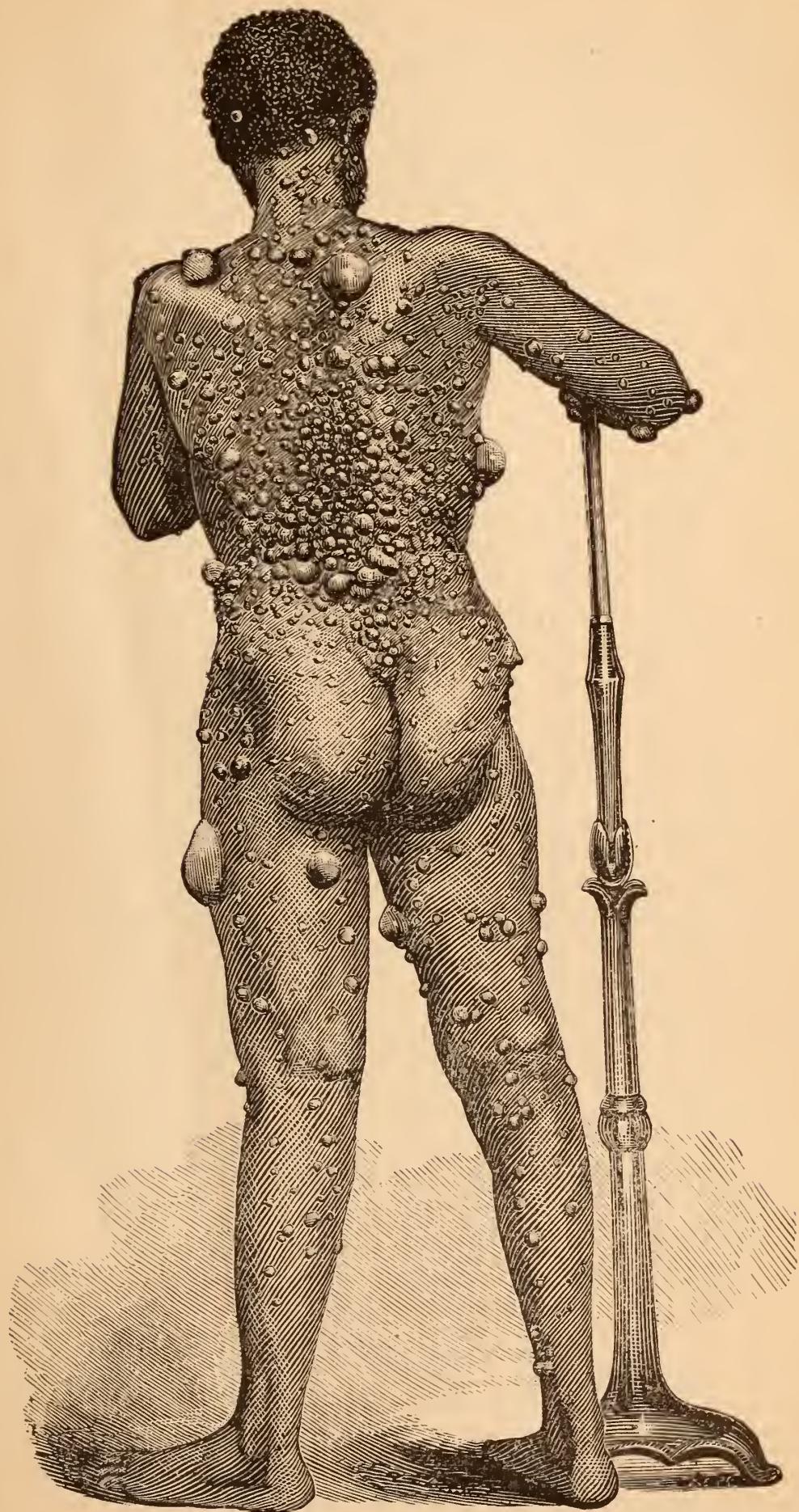
The disease first showed itself when she was about 11 years old, and the first tumor appeared on the posterior aspect of the left shoulder, and finally became one of the largest growth on her body, there being only two exceeding it in size. From this starting point they began to spread in every direction, until, as shown in the accompanying wood-cuts, they invaded almost every region of the skin.

The tumors were never painful, and the disfigurement and inconvenience of their presence were the only causes of her complaining of them. Those growing on the hairy scalp occasionally rendered it difficult for her to comb her hair, and she would then have one or two of the largest and most inconvenient excrescences snipped off with scissors. This gave sufficient opportunity for examining their structure, which was repeatedly done.

On the back they were most numerous, next the chest and abdomen, next the scalp and face in proportion to the surface. On the lower extremities the tumors were more numerous than on the upper; the anterior surface was not so thickly covered as the posterior. The buttocks and hips were comparatively free, and so, though in a less degree, were the extremities, especially the forearms and legs. The external genitals were covered with small tumors, and one of larger size was of such form and dimensions as to look somewhat like a penis. In the wood-cut it has been placed by the artist a little too far to the left side.

The soles of the feet were perfectly free, and so were the palms of the hands, except on the right, where a globular tumor was situated very near the wrist.

The tumors varied from the size of a mustard seed to that of a



hen's egg. The greatest diversity was noted as to texture and form, hard and soft, smooth, rough and corrugated, pisiform and pyriform, pendulous and sessile, globular, ovoid and lobulated, these and other shapes were all represented.

In order to ascertain the number of tumors, the surface of the body was marked off into regions with chalk, and these again into smaller sections. The tumors situated in each were then counted, with the following results :

There were, on the face and ears, 55 tumors; on the anterior aspect of the neck, 30; on the chest, 300; on the abdomen, 348; on the anterior aspect of the right upper extremity, 51; on the anterior aspect of the left upper extremity, 35; on the anterior aspect of the right lower extremity, 118; on the anterior aspect of the left lower extremity, 104; on the scalp 47; on the posterior aspect of the neck, 30; on the posterior aspect of the right upper extremity, 22; on the posterior aspect of the left upper extremity, 20; on the posterior aspect of the right lower extremity, 62; on the posterior aspect of the left lower extremity, 52; on the back, 1059. The total number of tumors counted was 2,333, but this falls short of the reality, as many of the smallest were covered by the larger ones and not included. The accompanying wood-cut, though a quite faithful copy of the photograph, taken during life, does not, at first sight, convey an adequate impression of the excessively large number of these tumors.

*Microscopic examination* showed that the tumors were composed, in great part, of connective tissue, with masses of nucleated cells collected between the meshes. In some specimens the sebaceous glands were enlarged and their sacculi separated, so as to present a racemose appearance. In others, these glands had become so compressed by the growth of connective tissue, that they were atrophied and destroyed.

The patient remained under observation for several years, during which time she was exhibited to numerous classes of medical students. Shortly before Christmas, and while intoxicated, she fell down the stairs and broke her back. Being unable to move, and alone in the house, she lay in the hall throughout the night, and, when found in the morning, she had perished from cold. At the time of her death she was about 64 years of age.

## Clinical Reports.

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### I. *The Local Treatment of Psoriasis.* By JOHN T. STANSBURY, M. D., Towsontown, Md.

BELIEVING that this is a strictly local affection, requiring only local treatment, I have, in the cases cited below, with a single exception, employed local remedies only; and while disclaiming any originality in the treatment employed, my success has been such as to lead me to suppose that they may prove not uninteresting to those concerned in the treatment of this disfiguring and constantly occurring disease.

*Case 1.*—A. R., aged 26, applied to me in May, 1873, for the treatment of a psoriasis, which he stated had existed for two years. The disease was located on the right shoulder and arm. The patches varied in size from a pin's head to the palm of the hand. He had taken a number of quack medicines, and had been treated by several physicians. When I saw him, he was taking Fowler's solution in ten-drop doses. I ordered the patient to discontinue the arsenic, and employ frictions with soft soap (*sapo viridis*) and warm water. At the expiration of a week, as the patches were somewhat softened and scales removed, I applied acetic acid as recommended by Dr. Buck, an abstract of whose paper I had recently seen. The diseased parts immediately turned white and puffed out, the surrounding skin became red, and, for a short time, the pain was severe. The patient, although complaining loudly of the pain, resolutely persisted in the treatment, and in nine weeks from the first application, the disease had disappeared. The skin had a clear, smooth appearance and it was impossible to point out the spots where the eruption had existed.

*Case 2.*—Miss R., Jewess, aged 17, came under treatment in May, 1873, for psoriasis of the right shoulder and breast. The disease had existed for four years, commencing on the shoulder, which was pretty well covered with patches from the size of a split pea to a silver dollar. Acetic acid was applied twice a day for two months

At the expiration of that time the disease disappeared. No relapse has occurred.

*Case 3.*—Mrs. J. S., aged 24, has had psoriasis of the left elbow and forearm for ten months. After frictions with soft soap, acetic acid was applied daily for six months. At the end of that time the eruption having entirely disappeared, the treatment was discontinued.

*Case 4.*—Miss E. L., aged 19, consulted me June 12, 1874, for psoriasis of the right cheek. The patch, about three-fourths of an inch in diameter, presented a bright red appearance, and had existed about six weeks. Upon further inquiry I discovered other and older patches of the disease about the hips and knees. She also suffered from neuralgic dysmenorrhæa. Bismuth ointment (3 ss to 3 i) was applied to the face, and the acetic acid to the other spots daily. For the neuralgia I prescribed a pill containing 1-20 gr. acid. arsen. in combination with quinine and extract of stramonium, to be taken three times a day, beginning three days before the expected menstrual period, and continuing for two days after its inception. An occasional cathartic was also prescribed. On June 20, the spot on face having become paler, I ventured to apply the acid. The diseased part immediately turned white, and the surrounding tissues became deeply congested. The pain was severe. I did not use the remedy again for several days, after which, however, it was applied regularly, and on August 6, just eight weeks after the treatment was begun, the patient was dismissed *cured*.

The above was the only case in which arsenic was given, and I feel sure that its most strenuous advocates will agree with me that the improvement was too rapid, to be attributed to the very small quantity of that drug which the patient had taken.

## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. BULKLEY.

*Sixty-second Regular Meeting, January 5, 1875.*

DR. WEISSE exhibited again his patient with *rodent ulcer* (Archives of Dermatology, October, 1874, p. 51), the disease having disappeared entirely after an attack of erysipelas which began November 6, and left the parts completely cicatrized by December 27. The acetate of zinc had been previously employed pretty persistently, but the ulcer had steadily progressed until the advent of the erysipelas. When shown there was a depressed red cicatrix, tolerably smooth, and with none of the hard beaded margin which it formerly exhibited.

Dr. STURGIS asked if there was not danger of a relapse, as long as the red color remains?

Dr. WEISSE thought that the mamellated points were the indication of a relapse, and these did not now exist.

Dr. OTIS remarked that he had seen tertiary syphilitic ulcers heal after erysipelas, also other ulcers.

Dr. TAYLOR mentioned that Mauriac had noticed ulcerations heal from the artificial erysipelas following a cauterization.

Dr. OTIS thought that the opinion expressed by the Society (Arch. of Derm., p. 51), in favor of excision, was borne out by the history of the case, its duration would have been much shortened thereby.

Dr. TAYLOR read the history of a case of *idiopathic multiple pigment Sarcoma of the skin.*

Dinah Johnson, a wash-woman, colored, aged 48, was first seen by me in June, 1869. She was of large frame and very corpulent, and had always enjoyed excellent health, as she stated that she was never sick in bed in her life. She was not of dark color but of a light brown. She showed me, on this occasion, a large flat tumor seated over the upper part of the sternum. In shape, this eleva-

tion was somewhat like the figure eight, being oval, with two corresponding central depressions. It was about three inches long and one-and-a-half broad at the widest part, and about three-eighths of an inch at the central constricted portion. It was raised above the plane of the thorax about half an inch, and its margins were rounded. In color it was of a very deep black, or, rather, bluish black, and at the margins the blackness extended for a line into the healthy skin. The surface of the tumor was smooth, except that the follicles were rather more prominent than usual, and a few tufts of very black short hairs were scattered over it. There never was any attendant pain, and the tumor gave the woman little concern. The history of its development was as follows: At the age of 24 a black speck appeared near the top of the sternum. This enlarged slowly, and was followed in a year by a similar one about two inches lower down. In the course of time they, growing gradually, joined together and reached their present size in about five years, remaining without apparent change since. But during this time tumors appeared on the forearms, abdomen, legs and thighs. For several years no new ones were formed, then, after an interval of about ten years, a new crop began to form, one on one palm and several on each sole, with others over the neck and scapular region. Another interval occurred—this time of about ten years—then new tumors appeared in the same localities. The course of these tumors was always slow and painless, and they were distinctly limited, and did not cause any hyperæmia of the integument around them. As said before, the patient's health did not suffer in any manner. When first seen by me the swellings were situated on the regions named; some were as large as a silver half dollar, but none had reached the size of the one on the sternum. I saw some which were beginning to form, and this gave me the opportunity of studying the early history of the disease. At first, simply a dusky appearance was seen. Soon enlarged capillaries were apparent, and then the elevation of the skin followed. Over some of the less matured the dilated capillaries were strikingly visible, while in others these vessels were seen around the margin in large numbers. The mucous membranes were not involved. These are the chief clinical features which I observed. I wished to excise the sternal tumor, and was prevented from so doing by the removal of the patient to the South. This case shows that the disease under consideration is not, as supposed by Kohn, necessarily fatal, and it goes to prove that the tumors may develop first, elsewhere than upon the soles of the feet. As regards the prognosis of the disease, my opinion is that it is not necessarily fatal, and that it only causes death when organs are much infiltrated which are necessary to the continuance of life.

Dr. KEYES said that in his case recited to the Society a year or two since, the tumors were sub-cutaneous and positively elevated to the size of a pea. They were enucleable and very vascular. Several of the tumors disappeared after being cut into.

Dr. BULKLEY referred to some peculiar features in the case of *melanotic cutaneous tumors*, which had previously been exhibited to the Society by Dr. Sherwell. He had since watched the case for some weeks. The disease had seemed to remain quiescent

for some time under the influence of Fowler's solution given by Dr. Sherwell, but the general health of the patient was now gradually failing. Large amounts of pigment matter were passed by the urine, that excretion being often of the color of clear coffee when passed, but becoming turbid from urates soon after. The tumors, especially on exposed parts, frequently bled profusely. They seemed at first beneath, or in the very deepest structures of, the skin, which was normal over them, but, as the disease progressed, the tumors seemed to come to the surface, the skin became blackened and adherent.

Dr. TAYLOR then read the second paper of the evening, "Syphilitic affections of the lachrymal apparatus" (published in the *Am. Jour. Med. Sci.*, April, 1875).

Dr. PIFFARD introduced the subject of *buccal psoriasis*, mentioning the case of a man, aged 31, who had had syphilis a year or two previously, and in whom, on the inside of the right cheek, there was an elevated, whitish patch which he did not regard as syphilitic, and proposed to remove. He said that some of the cases detailed by Debove as buccal psoriasis had had syphilis.

Dr. WEIR (by invitation) related two cases of *ichthyosis of the tongue*. One of the patients had had syphilis previously, but specific treatment failed to affect the disease of the tongue, and a section of one of tuberose masses showed the microscopic characters of epithelioma. In the other case of a man aged 41, who never used tobacco nor had syphilis, the tongue showed on each side, well back on the dorsum and stretching inward from the edges to the distance of half an inch, a pearly white patch, each a little over an inch long; they were irregular in outline, mottled, being apparently thicker in spots than in others, and very slightly raised above the surrounding healthy mucous membrane. They were somewhat less sensitive than normal, and, on being pinched between the fingers, felt like softened parchment. There was no inconvenience from them; no sensations of any kind.

Dr. KEYES had seen three cases (including one of Dr. Weir's), one of which was in a syphilitic subject, and yielded to fumigations of the tongue in addition to ordinary anti-syphilitic treatment. The whole dorsum of the tongue was elevated, of a yellowish, mother-of-pearl color. At the edges the epithelium grew out in triangular masses between the teeth, and when they were caught up by the forceps they escaped with a cartilaginous sensation. In the other case a white patch about three-quarters of an inch long by one-quarter wide existed on the floor of the

mouth in the region of the frænum. On excision, a horny, compact layer of epithelium was seen, but no epithelial nests.

Dr. BRIDGE said that he was applying the spray of a saturated solution of nitrate of silver with good effect, to a tongue covered with an extensive psoriatic patch. The patient had had syphilis, and was under specific treatment.

Dr. OTIS said that he had seen a number of these patches in syphilitic subjects which were due to syphilis, and disappeared under treatment; but he had also seen in a syphilitic a pearly-white patch on the tongue which had lasted eight or ten years without change, supposed to be caused by the end of a tube through which he had sucked a drink in South America. It had resisted treatment of every kind.

Dr. KEYES further recalled another patient, seen in Hardy's clinic, who had a whitened strip about one-half inch wide and slightly elevated, running obliquely across the tongue. He had general non-syphilitic psoriasis, and the disease of the tongue was considered to be part of it. He had never seen it thus associated in any other patient.

Dr. BULKLEY thought that it was important to draw a clear line of distinction between the various lesions which had been mentioned by the gentlemen in the discussion. Some of them were distinctly due to syphilis, and should no more be called psoriasis or ichthyosis, than should the scaly eruptions of syphilis on the skin receive the same name as those not of specific origin. It is not uncommon to have the mucous membrane of the mouth of syphilitic patients present opaline patches from time to time, which resemble those alterations called psoriasis buccalis and ichthyosis linguae, but, yielding to specific treatment, they must be considered as manifestations of the syphilitic poison. These lesions are quite different from those belonging to the true disease as described and delineated by Fairlie Clark and Debove, of which examples are not very uncommon. In regard to the connection of this disease with ordinary psoriasis, he had examined the tongue of very many patients with the latter affection and had never seen it implicated, although the tongues of old psoriatic patients are not unfrequently white all over from the amount of arsenic they have taken.

Dr. TAYLOR had used strong nitrate of silver spray in a case of horny psoriasis or ichthyosis of the tongue with no effect. He suggested the cautious application of a strong caustic potash

solution (3*i*, vel. 3*ii*, ad 3*i*). He had seen psoriasis of the tongue in connection with general psoriasis.

Dr. STURGIS mentioned a case in a man aged 30, on whose tongue there was a white, glistening band extending from tip to base, leaving the edges free. He never had had syphilis.

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*Sixty-third Regular Meeting, February 9, 1875.*

Dr. OTIS read the paper of the evening, entitled "Spasmodic urethral Stricture." (See p. 204, Archiv. of Derm.)

Dr. STURGIS recalled the fact that the deep urethra was usually considered the favorite seat of stricture.

Dr. OTIS considers that three-quarters of the strictures occur in the first inch of the canal.

Dr. STURGIS inquired what Dr. O. considered the normal amount of narrowing the urethra just behind the fossa navicularis?

Dr. OTIS said that there was no normal narrowing which could be detected by a bulb during life.

Dr. PIFFARD believed in spasmodic stricture; had known it to occur in a boy previous to any urethral disease. He had seen a case in a charity hospital similar to that detailed by Dr. Otis. Being called upon to examine a small stricture he slit the meatus, when a full-sized sound passed in to the surprise of all.

Dr. FOSTER mentioned a case occurring in the New York Hospital, where no member of the house staff nor the attending surgeon could pass an instrument. When etherized a full-sized sound passed readily into the bladder. Dr. F. thought that there might sometimes be congestion besides the spasm, or even a spasm of the prostate or vesical sphincter. He believes in the slow pushing of a conical bougie in overcoming spasm.

Dr. TAYLOR narrated the case of a boy who masturbated and had urethral troubles, dribbling, retention, irritability of bladder, etc., with well-marked phymosis. A bougie was arrested at membranous portion. There was some slight balanitis. Circumcision effected a complete cure. In another case in a young man, where there was retention, a No. 12 silver catheter could be passed. Circumcision was advised in this case.

Dr. KEYES recalled several isolated instances, going to prove that narrowing of the urethral orifice had much to do with irritability of the bladder. He also recalled that the teachings of others had already inculcated the value of slow and steady, but light pressure against the face of spasmodic strictures.

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*Sixty-fourth Regular Meeting, March 16, 1875.*

Dr. FOX exhibited a case of *epidermic favus in combination with tinea circinata*.

A girl, aged 13, presented over forty isolated patches of eruption, manifestly of a parasitic nature. Some were about the size of a small cent, others larger and smaller, elevated especially at the margin, and covered with small, thin, epidermic scales. A larger oval patch, presenting the ordinary aspect of ringworm, was situated below the left clavicle. The scalp was unaffected. Upon a few of the patches on the left breast some favus cups the size of a pin head, with depressed centers, were seen, together with minute yellowish spots at the mouths of the follicles. Microscopic examination revealed the spores of the achorion in abundance, while the epidermis from other patches showed simply the mycelium and small spores commonly observed in the varieties of trichophytic disease.

Dr. WEISSE thought the characteristics of favus were quite marked.

Dr. PIFFARD considered that the diagnosis between favus of the epidermis and tinea circinata was difficult both to the eye and the microscope. The only sure method was an examination of the hairs, which were altered in tinea circinata in a manner not found in favus.

Dr. KEYES doubted if the two diseases were here present, but suggested covering a spot by a watch crystal and observing the undisturbed development of the disease.

Dr. FOX said that, were it not for the minute favus cups, he would have considered the case simple ringworm.

Dr. KEYES suggested that there was no clearing of the center of the patches as seen in ringworm.

Dr. TAYLOR regarded certain patches as typical of ringworm, while other portions resembled favus of the epidermis.

Dr. WEISSE quoted Hebra's plate of the two combined.

Dr. BULKLEY recalled a case of epidermic favus recently seen,

where the appearances closely resembled those in this case. Here he watched the disease develop from a typical crust, and he thought that, in the present case, there was more likely but one disease and that favus.

Dr. TAYLOR thought the elevation greater than in favus epidermidis.

Dr. BULKLEY showed a child with an unusual form of development of *eczema in a very scrofulous subject.*

The child, L. R., 2 years and 2 months old, had an ordinary eczema at the age of 3 months, which disappeared after five months' treatment. The present eruption appeared two or three months ago, and has had, from the first, the same general characters as at present; has never been moist. On inspection the body, especially about the thighs and buttocks, is quite thickly covered with a dry, papular eruption with slight scaling. The papules composing the eruption are of a purplish red color of a rather large size, though but little elevated, and resemble much those of lichen ruber planus. The child is very scrofulous in appearance, of a pale pasty color, and with very great glandular enlargement of the right cheek with abscesses.

Dr. DAY thought that the marked scrofulous diathesis present could readily modify an eczema to this extent.

Dr. WEISSE remarked that this was an eruption which would be called *scrofulide squameuse* by Bazin.

Dr. PIFFARD had seen the identical lesion in a woman, where there was no evidence of scrofula. He was doubtful as to the diagnosis in that case, and is in the present instance.

Dr. SHERWELL inquired if there would not have been moisture at some time if the disease were eczema, or, at least, infiltration?

Dr. TAYLOR said that some cases showed no moisture throughout their whole course. He remarked that the itching was slight, and was apt to be so in scrofulous subjects.

The paper of the evening was then read, namely, the "*Report of the special committee on the subject of the classification of diseases of the skin.*"

Your committee have held several meetings besides occasional conference with each other, and have duly considered the subject of the classification of diseases of the skin, with especial reference to that presented by Dr. Piffard (Archives of Dermatology, April, 1875, p. 216, ED), and would report as follows:

While it is highly doubtful if, at the present stage of our knowledge in regard to the pathology and etiology of disease in general, and of skin diseases in particular, there can be any system of clas-

sification devised and elaborated which will fully cover the ground and prove satisfactory to the student, teacher and practitioner, it is nevertheless true that the aim of the scientific medical man should be to so arrange and classify the diseases that he meets with that, in speaking or writing, others may understand what is meant. In the words of the committee on general classification of the Royal College of Physicians, London, "A good classification aids and simplifies the registration of diseases, helps toward a more easy comparison and knowledge of them, and toward the storing of experience respecting them, and facilitates the discovery of general principles from the collected, grouped and compared phenomena. But a good classification is a very difficult matter." And they continue: "After much consideration, the committee have resolved that the proposed classification of diseases should be based on anatomical considerations."

In like manner the committee of the New York Dermatological Society have, to the best of their ability, with the limited time at their disposal, endeavored to weigh the evidence respecting dermatological classification, and have resolved as follows:

I. That no classification of the diseases of the skin has yet been devised to the knowledge of your committee, which is sufficiently perfect and useful to receive the sanction and authority of this Society.

II. That your committee are not at present prepared to submit a new or better one than those already published.

III. That the first step to a correct classification is a correct nomenclature of disease, and your committee respectfully suggest that this Society undertake to prepare a nomenclature, based on the Latin, in which synonymous terms may be stated, in order that the profession of this country may have an uniform guide for the registration of diseases affecting the skin.

With regard to the special work intrusted to the committee, the examination of the "New Clinical Classification of Diseases of the Skin," presented by Dr. Piffard at the sixty-first regular meeting of the Society, December 8, 1874, your Committee would remark:

I. The five general divisions, of A. General Diathetic Affections; B. General non-Diathetic Affections; C. Reflex Affections; D. Local Affections; E. Affections of Uncertain Nature, we should consider well taken, in so far as relate to the classification under consideration, if the individual diseases could be all properly grouped, mainly in the first four classes; but it is certainly an element of great weakness in any classification to have the last class of "Affections of Uncertain Nature" existing at all, especially when the diseases embraced under it are so many and so heterogeneous. The existence of many diseases which may very properly be placed in the first four groups of this classification is undoubted.

II. The first variety of General Diathetic Affections, namely, *Syphilides*, cannot but be accepted by all acquainted with the subject, the subdivisions given being those accepted by most recent writers of note.

III. In regard to those denominated *Scrofulides*, there must exist some doubt, although the present division follows Hardy exactly. We cannot but feel that simplicity and clearness are in a measure sacrificed by thus attempting to mark off a class or variety of affections of the skin as due to so uncertain a cause as scrofula. The analogy between the diathesis of syphilis and scrofula is daily losing ground.

IV. The designation *Rheumides*, which is here inserted to represent the dartrous or herpetic diathesis of the French school, your committee cannot approve of, both because we deem innovations undesirable in the present unsettled stage of dermatological nomenclature and classification, and because the popular ideas represented by the terms rheumatism and salt-rheum, rheumides and rheumic diathesis, are unworthy of scientific support.

V. With reference to the diseases included under this head, eczema, psoriasis and pityriasis, the acceptance of this classification implies belief in the doctrine of their dependence upon some diathesis, here called rheumic, the herpetic or dartrous of the French school. This, we believe, the profession of America are not prepared to do, first, because a large number of cases of eczema are seen in the so-called scrofulous subjects and are recognized by most writers to be thus connected; second, because in another large share of these cases no trace of the existence of such a *rheumic* diathesis can be made out; and, third, because other diseases besides those here mentioned are recognized by others, as Bazin, to be associated with the arthritic and dartrous diatheses.

VI. From the *General non-Diathetic Affections* your committee would discard scorbutus and glanders, and substitute for the existing name of the Group, that of the "Eruptive Fevers," including erysipelas, a generally accepted division.

VII. The *Reflex Affections*, which term your committee think no improvement on, nor does it take the place of the generic title "Neuroses," are open to criticism in regard to some of the diseases there placed. Acne and its rosaceous form which is here made a separate affection, gutta rosea, following certain authors, while often directly symptomatic of disturbances of the digestive or sexual organs, can hardly with propriety be classed as always reflex affections and be placed along side of zoster, pemphigus and urticaria. Too little is known as to the etiology of xanthoma to allow of placing it here.

VIII. The division of *Local Affections* is one of the strong points of this classification, and the first, or parasitic class, admits of little

criticism. Your committee, however, cannot subscribe to the nomenclature here employed.

IX. The position of furuncles and anthrax among local affections might well be questioned, in view of the association of phlegmonous inflammation with glycosuria, and, further, the great benefit often derived from internal medication in these states.

X. It is, however, the last division, namely, *Affections of an Uncertain Nature* which demonstrate the exceeding great difficulty of accurately and satisfactorily grouping together the affections of the skin. Of course the members of this class have nothing in common, and we can only regret that seventeen diseases (and we believe that there are others which do not appear at all in this classification), and many of those seventeen of great importance, should occupy so anomalous a position.

In conclusion, taking a careful survey of the attempts which have been made from time to time to reduce to order the heterogeneous mass of cutaneous maladies, your committee is impressed with the fact that the time has not yet arrived when diseases of the skin can be grouped on a clinical or purely etiological basis. For while a few groups, as syphilis, the parasitic diseases, the eruptive fevers, and possibly a few other scattered diseases have their etiology pretty clearly made out, it must be confessed that the greater part of these maladies occupy still a *terra incognita* as to causation. As Liebermeister says in the introduction to the article on infectious diseases in Ziemssen's Cyclopaedia, 'The great advances which pathology and diagnosis have made in the present day are attributable mainly to the carrying out of this principle,' (of basing a classification on pathological anatomy), although it is likewise true that "the idea of causality represents the last point to be reached, and accordingly the most scientific rule of classification must refer to causes." He further says: "We are certainly far from having a complete etiological classification, because our knowledge of the causes of disease, which have only very lately been subjected to a systematic investigation, is still confined to the first rudiments. The unities of disease are still mostly anatomical; indeed, in many departments, we have not even reached this point, but are still obliged to recognize symptomatic unities."

What is here true of general diseases is especially true of those affecting the skin, and while a careful investigation of the causes of these affections will eventuate, we hope, in laying a basis on which a correct and serviceable etiological and clinical classification can be built, your committee believe that sufficient data have been by no means collected as yet.

*Signed by the Committee.* { L. D. BULKLEY,  
F. D. WEISSE,  
GEORGE HENRY FOX.

## Extracts and Translations.

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### THE ACTION OF OPIUM IN SYPHILIS.

BY JOHANN DAVID SCHOEPFF.

*Surgeon of the Anspach-Bayreuth Troops in America.*

TRANSLATED BY JAMES R. CHADWICK, M. D., OF BOSTON.

[This letter was one of three addressed to Professor Delius, and published by him in the form of a pamphlet in Erlangen, 1781. So far as I can learn, they are unknown in this country. The observations recorded seem to have been thorough, and to be of considerable medico-historical interest, even if more recent investigations have failed to corroborate them. The author was a man of note, and subsequently rose to considerable eminence in Germany. On the termination of our Revolutionary war he traveled through some of the Middle and Southern States, and published in German an extensive account of his experiences, in two volumes.—TRANSLATOR.]

The extraordinary action of opium in curing venereal diseases seems to be the most important matter in the domain of medicine, about which I can at present write from this place. This fact, which, like many others, was discovered by mere chance, has now been tested by many experiments during more than a year, and has been almost universally corroborated.

A young man of good standing, in England, had, for some time, been greatly reduced by a most virulent attack of this pest, in the shape of obstinate ulcers. He had sought in vain, for relief, from many of the most renowned physicians, and had unavailingly gone through the whole category of ordinary remedies. He had already taken a great amount of mercury in its different forms, and in accordance with the various methods of administration, but invariably without the slightest alleviation. Peruvian bark, mineral waters, milk, abode and exercise in the country—in short, whatever offered the least promise of relief, in his desperate condition, was tried without the slightest benefit.

Incessant pain, and, above all, bitter remorse, seemed to consume what little strength remained to him, and to hasten his steps toward the grave. They likewise robbed him of his sleep, the sole friend of the miserable. Under these circumstances opium was administered to him, more from pity than from the expectation of any other benefit. He began by taking a grain at a time, and gradually increased the amount. The refreshing effect of the sleep thus pro-

cured was a sufficient incentive to him to continue the use of this drug, and to increase the doses little by little. The improved appearance of his ulcers, the absence of pain, and the diminution of the other symptoms, soon, however, convinced him that the action of this remedy was more general than had been supposed by those who had first suggested its employment, and who now witnessed the result with astonishment. Nothing more was needed to recommend its further administration, and, after a short time, the patient had the inexpressible pleasure of seeing himself saved from the jaws of death. This is a truthful story, which must needs arouse the interest of every philanthropic physician.

There was a greater number than usual of venereal patients in one of the royal hospitals last winter under the charge of Mr. Grant, and the majority of these were afflicted with very obstinate foul ulcers, which did not yield to any of the common mercurial remedies. Dr. Nooth, Superintendent General of all His Majesty's Hospitals in North America\* (whose profound erudition, extensive experience, and Hippocratic sagacity raise him to the foremost rank of practitioners, and make him one whom I take pride in calling my friend), had for a long time entertained the opinion that the common way of treating venereal ulcers was, in most cases, erroneous; that the patient's strength was likely to be sapped by the internal administration of quicksilver; that the healing of the ulcers was retarded; that a more rapid recovery ordinarily resulted, if the venereal poison on the surface of the ulcers was destroyed by caustics, for which purpose the solid nitrate of silver was the best adapted; and, finally, that more certainty of a permanent cure could be had, if the mercurials were not employed until after the ulcers had been made to heal. This opinion, which was based upon antecedent experience, was newly corroborated by the ineffectual attempts made to cure, by means of quicksilver, the numerous cases of venereal ulcers, to which I have just alluded.

As Dr. Nooth was personally acquainted with the young man, who owed his wonderful recovery to the use of opium, and was moreover convinced of the truth of his narrative, he ordered that a trial of opium should be made upon the patients in the hospital, before any other treatment was employed.

\*If this title is correct, Dr. Nooth must have been promoted during 1779 or 1780, for the following is a list of the "Staff officers of his Majesty's Hospital at New York," in 1779: "Michael Morris, Physician and Inspector; Charles Blagden, Physician and Inspector; J. Mervin Nooth, Physician, extra, and Purveyor; Jonathan Mallet, Chief Surgeon and Purveyor; Alex. Grant, Surgeon and Field Inspector; Rob. Roberts, Director and Purveyor of Hospitals for Prisoners; Rich. Hope, J. Macnamara Hayes, Hammond Beaumont, James Audinleck, Surgeons. A list of the General and Staff officers, etc., serving in N. America, under the command of his Excellency Gen. Sir Henry Clinton, K. B. By authority, New York, 1779." — TRANSLATOR.

With this end in view, cases were selected, which were as nearly alike as possible, and quicksilver given to one series, while opium was given to the other. One grain of the drug was administered at the outset, and the dose increased to five, six, eight, or more, grains a day. The patients felt unusually well under this course of treatment. No unnatural sleep was produced, but a sort of restfulness and freedom from all unpleasant sensations led the patients to assert that they felt better after taking these remedies than ever before, although they did not know what had been given them, and consequently had not had their imaginations aroused. The decided change for the better, which became evident after a few days, from the abatement of the hard and inflamed edges, the improvement in the character of the discharge, and the generally healthy appearance of the ulcers, fully confirmed the statements of the patients. In those, on the contrary, who were treated with mercurials, no progress had been made during the same periods; the rapid improvement of their comrades was, however, so strikingly manifest to them that they soon begged for the same pill. The use of opium was therefore persisted in, and even extended, where such a course appeared to be indicated, and the physicians soon had the satisfaction of seeing all, to whom it was administered, freed from their ulcers and all other symptoms in a shorter time than they had thought possible.

One remarkable fact about this remedy is that no disturbance of the bowels is produced, the patients having as usual their regular daily evacuations, not excepting those who are taking 10 to 15 grains a day; if any constipative effect is observed, a very small dose of salts is always sufficient to re-establish the customary regularity.

From the beginning I have been an eye-witness of the majority of the experiments made in the royal hospitals,\* and of their happy results. Records have been kept of the various cases, which will, I hope, soon be made public. Since that time I have been no less fortunate in all the cases where an opportunity has presented

\* The first medical school in New York was organized under the direction and government of the College of the Province, then called King's College. The English converted the college into a military hospital. After the war King's College was revived under the name of Columbia College, and in 1792 the Medical School was re-established. Between 1792 and 1811, only 34 students took medical degrees. The Regents of the University of the State of New York, in whom resided the exclusive power of instituting seminaries of learning, determined in 1807 to found the College of Physicians and Surgeons. The College of Physicians and Surgeons and the Faculty of Physic of Columbia College were united in 1813. — TRANSLATOR.

of testing this action of opium in our corps. The stricter supervision over our men renders the venereal disease rarer among them than in the rest of the army, although some injure themselves by concealment, owing to a dread of the penalty. A musketeer of Von Siebold's Regiment was brought to the hospital last September on account of a clap, which he had sought to hide; he was found to have paraphimosis, which had resulted in gangrene. When first examined after his arrival from the camp, the prepuce fell off spontaneously, as did a portion of the glans,—almost half of the member was completely gangrenous, and the rest still greatly inflamed. The stench was intolerable; the patient feverish and very weak. He had already been under my care for a peculiar swelling and an uncomfortable sensation in the right hypochondriac region, brought on by lifting a heavy load; this had been slowly improving, but was not altogether relieved. In his present condition my first idea was to prescribe Peruvian bark, both internally and externally, in order to arrest the progress of the gangrene and to hasten the separation of the slough. The recently discovered favorable action of opium in gangrene and my own experience of its use in venereal cases, induced me however to give it a trial, and with all the more confidence, because in this instance one of these conditions had resulted from the other. Poultices sprinkled with oil and laudanum were consequently applied to the affected part, and a grain of opium administered four times a day. The inflammation, which had not subsided and the tension in the posterior part of the organ, had been extremely painful before his arrival. The pain was, nevertheless, quickly alleviated, so that he passed the very first night undisturbed, and had a regular movement of the bowels the next morning; on the 3d day the inflammation had greatly abated and much of the slough come away; on the 5th or 6th the inflammation was entirely gone and the remainder of his penis looked perfectly clean as though it would heal rapidly. The poultices were omitted, and the organ dressed first with dry compresses, and later with simple balsamic lotions; the opium was however continued internally until the recovery was perfect a few days after, without the supervention of any symptoms either venereal or of other nature. I cannot determine just how far this experience may be regarded as convincing, for, under other systems of treatment, gangrene of the male genital organ due to phimosis, very seldom extends farther than the antecedent inflammation and constriction of the prepuce. Whether the result was

the work of nature, or of the remedies employed, is undetermined, but it is at all events certain, that, if other drugs can benefit such a case, the same effect can also be produced by opium.

I could extract from my record book many other instances in which chancre and venereal ulcers on various parts of the body have been entirely cured by this treatment, were such a course not too diffuse for the limits of a letter. I can, however, assure you, that not one of the venereal patients which have been under my charge, during the past ten months, has taken even a grain of mercury, and I still have no reason for substituting the latter for opium. That the same has been the experience in the royal hospital, I can testify, both as an eye-witness and from the statements of those who are connected with it, and who are more and more pleased with the action of opium, and employ it more extensively. The case, in which its advantages were first recognized, gave rise at the outset to the supposition that benefit was chiefly to be expected in ulcers, but numerous recent experiments have since taught us that other venereal symptoms may be quite as surely relieved by opium. Only a few days ago I saw some figwarts\* in one of our grenadiers disappear within a week after opium was administered. In the hospital at Vauxhall, where, along with our patients, the women of the armies are admitted, half of whom may always be placed in the category of loose-women, I have had daily opportunities of seeing such recover under the influence of opium from every variety of manifestations.

Whether the power, which opium possesses of healing venereal diseases, can be ascribed to its tranquilizing antispasmodic qualities, and to that of diminishing the sensibility of the nerves, or whether (as is probable) it is, in addition, a direct antidote to the venereal poison, I do not venture to determine, until more extensive experiments yield a decided answer. The action of the venereal poison, in its early and later manifestations, is always corrosive; pain, redness, swelling, inflammation, with their sequelæ, are the most evident proofs of this peculiarity, and make it easy to understand the efficacy of the poppy-juice in one class of cases. In other classes, and especially where a complete eradication of the poison, when it has been acquired by contagion, is sought by means of opium, I can, as yet, only state that those, who, during the past twelve months, have been easily, surely, and speedily cured of tedious and previously intractable

\*Condylomata.

lesions by its use, have good reason for expressing the opinion and hope, that this drug possesses more than an indirect action upon the seeds of these affections. This belief is all the more justifiable, because during this period we have met with no instance of a relapse among those who have been treated on this plan. Moreover, if it is true — as is asserted by nearly all travelers, and cited as remarkable, even by Voltaire in his "Candide" — that syphilis is but little, if at all, known among the Turks, Persians, and other oriental nations, should we not, supported by our experiments, ascribe this fortunate freedom from so common and distressing a scourge of Christian Europe to the wide-spread and constant use of opium, not being unmindful, however, of their daily resort to baths.

Should the present prospect of a radical cure of syphilis not be borne out by the experience of the future, or be found permanent, nevertheless the advantages incident upon the use of opium will always far surpass those of mercury. The accumulated experience of several centuries in the employment of mercury has not as yet supplied us with any reliable sign which will enable us to give the patient an assurance of the complete elimination of the poison; much less can we promise that the earlier or later evil consequences of the poison or its antidote are arrested.

None of the many bad effects so generally observed by those who have had to employ mercurials, and to repent of it afterward, seem to be attributable to opium. Since the consumption of this drug, which has for so long been universal in the East, has not made evident any special injurious action, either upon the health in general, or upon any particular part of the economy, and inasmuch as the indolence of those peoples may be regarded, not as a consequence of the use of opium, but rather as an inherited disposition, or a habit engendered by the climate, and by social and political influences, it is altogether impossible that its use, when restricted to a moderate period of time, or when taken in increasing and decreasing doses, can be injurious. Nothing has as yet come to our notice which could in the least detract from the high opinion we have of it, and from our expectation of seeing its benefits universally corroborated.

This is the most satisfactory account that I can give you on this topic. If you consider the matter of sufficient importance to publish, it is at your disposal; its publication would moreover save me the trouble of giving several of my friends an account of our investigations, as I wish to do.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### DIAGNOSIS, ETIOLOGY, THERAPEUTICS, ETC.

E. B. BRONSON, M. D.

1. **Piffard, Henry G.** — Methods of physical investigations in dermatology. *Phila. Med. Times*, March 27, 1875.
2. **White, James C.** — The poisonous action of tincture of arnica upon the skin. *Bost. Med. and Surg. Jour.*, Jan. 21, 1875.
3. **Renault.** — *Essai sur l' influence de l' alcoolisme dans le développement de plusieurs groupes d' affections cutanées*. Thèse. de Paris, 1874.
4. **Besnier, Ernest.** — *De l' emploi des tissus imperméables et notamment de la toile de caoutchouc dans le traitement des affections de la peau*. *Bul. Gén. Théra.*, 30 Jan., 1875.
5. **Da Silva Lima, J. F.** — *Goa powder*. (Translated and annotated by J. L. Paterson, M. D.) *Med. Times and Gaz.*, March 6, 1875.
6. **Barduzzi, Domenico.** — *(Dell' uso del fosforo in alcune dermatosi croniche.) Phosphorous in Skin Diseases*. *Giorn. Ital. della Mal. Ven. e della pelle*, Dec., 1874.
7. **Callender.** — *Antiseptic Japanese paper as a dressing for wounds and ulcers*. *Brit. Med. Jour.*, March 6, 1875.
8. **Dubois.** — *Tincture of iodine for cloasma uterina*. (Gaz. Hebdom.) *Med. Rec.*, May 1, 1875.

PIFFARD (1) calls attention to certain methods by means of which we may avail ourselves more fully of the assistance which is derived from the physical senses, in the study of the skin and its lesions. Beside the compound microscope, which he has adapted to replace the simple lens, and a description of which was communicated to a recent number of this journal (Vol. 1, No. 2), he describes a somewhat modified form of the cutisector,

invented by him some years ago, and reported in the Am. Jour. of Syph. and Derm. Reference is further made to various other aids to the physical diagnosis of cutaneous affections which he thinks are too apt to be neglected.

WHITE (2) protests against the popular implicit faith in arnica as a perfectly harmless topical remedy. He presents three cases where the application of the tincture for bruises, rheumatism, etc., was followed by severe eruptions of acute eczema. In a foot note he refers to a case recorded in the last annual report of Hebra's clinic, where a serious dermatitis was produced, accompanied with destruction of a portion of the tissues, in consequence of the external use of this drug.

BESNIER's article (4) on impermeable dressings, aims to give a more detailed account of the mode and range of application of this method of treating cutaneous disease than has been hitherto presented to the profession. The method was first proposed by Colson, and introduced to the profession generally by Hardy. It has been employed with satisfactory results in Vienna, and doubtless elsewhere, but so far as we are aware it has not yet been so commonly adopted as its peculiar advantages would seem to merit. It is noteworthy that Besnier does not confine its use to eczema, but claims that it is applicable generally where an emollient dressing is indicated, more particularly, whenever the nature of the affection is markedly inflammatory, and there exists a disposition to the formation of crusts upon the surface of the skin, together with fissures or thickening of the cutis. We find such characteristics in eczema, impetigo, ecthyma, lichen, and in all forms of prurigo, where intense itching is the prominent feature. In all of these affections the impermeable dressing is almost certain to give relief, and often suffices to effect a cure. For eczema and impetigo, it is applicable at all periods of the disease, unless in the very earliest or in the final stages. At the first commencement of the affection, more strictly emollient applications may be desirable, in the form of powders of various kinds, while at the final stage, a more stimulating or alterative treatment is sometimes necessary.

It is especially recommended that the dressing be employed in the affections of the hairy scalp accompanied with copious exudation. Under these circumstances recourse is very generally had to a poultice—always an objectionable remedy—for which a skull cap of vulcanized rubber may be substituted with all the

advantages retained, which are anticipated from the former, while the objectionable features are avoided.

Where the type of the cutaneous disease is less markedly inflammatory and of a more specific nature, B. regards the impermeable dressing as, generally speaking, contra-indicated. Thus, in pemphigus, general psoriasis, erysipelas, the syphilo- and scrofulo-dermata, this method of treatment, as a rule, is inappropriate. The writer has seen its application in a case of psoriasis universalis followed by a severe dermatitis which even threatened life. The general rule, however, is not without its exceptions. Strictly localized affections are sometimes decidedly benefited by its use; in circumscribed patches of psoriasis it is often of great service in removing the crusts, and in the exudative stage of pemphigus, B. has occasionally found that no other measure could replace it as a means of allaying the intolerable itching. Moreover, in the local inflammations of syphilis or scrofula, wherever an emollient is demanded, the rubber dressing may be used with advantage.

The mode of application is described as extremely simple. The tissue employed may be either oiled silk or thin sheets of India rubber, or thin rubber cloth. The rubber cloth generally answers all purposes, the only objection to it being its disagreeable odor; to this, however, the patient becomes readily accustomed. With a few stitches of the needle it may be given any shape desired, and it may be fitted to all parts of the body. If applied to a flat surface, as upon the trunk, it is retained in place by strips of plaster, a bandage, or by any other simple dressing which may suggest itself.

The precise mode of action of the impermeable dressing is somewhat obscure. B. thinks it acts in a complex way. The most important effect is, perhaps, due to the exclusion of the air and to the prevention of the irritations from clothing, etc. The abundant secretion from the sweat glands which is immediately excited, besides exerting possibly some depletory effect upon the blood vessels, provides a fluid at the temperature of the body in which the irritated surface is continually bathed. The chemical action of the sulphur contained in the rubber has sometimes been regarded as the curative agent. While this may be of a certain importance, B. thinks that only a minor share of the beneficial result can be ascribed to it, since about the same advantage is derived from oiled silk as from the rubber.

(5.) In the *Medical Times and Gazette* of October 24th, was a paper by Dr. Fayerer of Calcutta, on a secret preparation known as goa powder, in use in India for the treatment of certain cutaneous diseases, herpes circinatus, chloasma and intertrigo. He further mentions another remedy very similar to the goa powder, which bore the name of Poh di Bahia. The sources from which these powders were derived were unknown. Dr. SILVA LIMA (5) now writes from Bahia, in Brazil, stating that a remedy has long been in use there for the treatment of the same diseases mentioned by Fayerer. The drug is there known as araroba powder, while in other provinces it bears the name of po' de Bahia. Araroba is the name of a tree belonging to the Leguminosae and the powder is supposed to consist of the pith. It is sold in the form of a coarse powder, or in small pieces of different sizes, and has a light yellow color, becoming much darker on exposure to light and moisture. The effects are exactly the same as those of the goa powder, causing irritation and discoloration of the skin. It is employed, as a topical application, mixed with vinegar. There can scarcely be any doubt of the identity of the three powders. An explanation is given of the manner in which the araroba powder found its way into India, under the name of Poh di Bahia, which is interesting and appears quite plausible.

10. **Bulkley, L. D.**—Analysis of 1,000 cases of skin disease with cases and remarks on the treatment. *The American Practitioner*, May, 1875.

BULKLEY (10) reports 1,000 cases of skin disease which were treated by him and his associates at the Outdoor Poor Department of Bellevue, during the year 1874. The cases are arranged in two tables; in the first, the diseases treated are given in their alphabetical order, together with the total number of cases of each disease, and the number occurring in either sex. In the second table the diseases are ranged in their order of frequency, and the percentage of cases of each disease is given. The greatest number of patients were women—574 females to 424 males. This excess of females is not supposed to imply necessarily that women are more subject to diseases of the skin than men, but the fact should be taken into account that for various, obvious reasons women are much more apt to avail themselves of the dispensary treatment. Some effort is made to trace a connection between the frequency of certain of the diseases and the rank in life to which

most dispensary patients belong. Thus some points of disparity between Bulkley's statistics and those of Wilson or others are explained on the ground that their statistics were derived from different classes of society.

An unusually large proportion of acne cases are recorded (11 per cent). According to McCall Anderson, these cases are less frequent by half among the poor of Glasgow. The discrepancy is believed to be owing to the fact that the Scotch live so much out of doors, are plain in their habits of life, and have a "national fondness for oatmeal," while with Americans the common habit of frying the food, "together with the great use of potatoes and the over indulgence in tea are prolific sources of acne." But while acne is more common here than in Scotland, the diseases "preventable by cleanliness" (parasitic diseases particularly) would appear to be much less prevalent.

Especial attention is paid to the treatment which was pursued. We note particularly that in the treatment of eczema Bulkley has in many cases substituted for the *sapo viridis* the common American soft soap, "with almost, if not quite as good results," and that he has met with success in the treatment of acne by Gubler's method of the internal administration of glycerine.

## II. Squire, Balmanno.—Do certain occupations produce skin diseases?—Medical Times and Gazette, May, 1875.

SQUIRE (11) gives statistics collected from the records of the East and West branches of the British hospital, for diseases of the skin, extending over a period of five years, which relate particularly to the influence of occupation upon the production of skin diseases. Two tables are presented, which are arranged with a special view to a solution of the inquiry set forth in the title. The result, it is thought, does not imply an affirmative answer.

The proportion of cases of cutaneous disease occurring in each occupation is obtained by dividing the whole number of people (male or female) engaged in all of the different pursuits (as established by a state census) by the number of cases of skin disease that occurred in each occupation. Further, "a mean liability by which each of the two tables may be absolutely gauged, is arrived at by dividing the total number of the male population of London by the total number of males attending the hospital during the past five years. This process gives a mean average

liability in the case of males, as applied to these tables, of 1 in 70. The same process applied to the case of females gives a mean liability of 1 in 100. The occupations in each of the two tables are not stated in alphabetical order, but, as will be seen, in the order of comparative liability to skin disease. Consequently, in the table of occupations of males, all those occupations which precede the figure "70" in the column of figures, come out as specially predisposing to skin disease in the order of precedence here given them, whereas all the remaining occupations stated in that table, appear as specially exempting from skin disease in adverse order to the order of precedence here assigned to them. So, again, in the table of occupations of females, with regard to occupations, respectively, above or below the figure "103" in the table."

#### COMPARATIVE LIABILITY TO SKIN DISEASE

##### *Occupations of males (five years' statistics.)*

Leather cutters .....	1 in 7	Tanners .....	1 in 70
Weavers .....	1 in 14	Brush makers .....	1 in 71
Dyers .....	1 in 16	Porters .....	1 in 71
Gardners .....	1 in 20	Cabmen .....	1 in 73
Cellarmen .....	1 in 22	Cigar makers .....	1 in 75
School teachers .....	1 in 23	Engineers .....	1 in 79
Paper hangers .....	1 in 26	Painters .....	1 in 82
Warehousemen .....	1 in 28	Wheelwrights .....	1 in 83
Clerks .....	1 in 31	Opticians .....	1 in 84
Carvers and gilders .....	1 in 33	Barmen .....	1 in 85
Wood carvers .....	1 in 33	Coopers .....	1 in 89
Cabinet makers and upholsterers .....	1 in 36	Gun makers .....	1 in 90
Engine drivers .....	1 in 36	Coachmen .....	1 in 91
Railway servants .....	1 in 37	Watchmakers .....	1 in 92
Stone cutters .....	1 in 37	Confectioners .....	1 in 93
Turners .....	1 in 38	Hatters .....	1 in 93
Book binders .....	1 in 39	Laborers .....	1 in 95
Travelers .....	1 in 44	Brewer's servants .....	1 in 107
Gas fitters .....	1 in 47	Domestic servants .....	1 in 109
Harness makers .....	1 in 49	Police .....	1 in 114
Brass workers .....	1 in 50	Boot makers .....	1 in 114
Tailors .....	1 in 50	Cork cutters .....	1 in 124
Jewellers .....	1 in 51	Iron workers .....	1 in 127
Printers .....	1 in 52	Plasterers .....	1 in 124
Mast makers .....	1 in 54	Soldiers and sailors .....	1 in 125
Masons .....	1 in 55	Dairymen .....	1 in 133
Bakers .....	1 in 56	Butchers .....	1 in 135
Carpenters .....	1 in 60	Bricklayers .....	1 in 165
Grocers .....	1 in 60	Carmen .....	1 in 191
Musicians .....	1 in 61	Builders .....	1 in 202
Umbrella makers .....	1 in 61	Ship workers .....	1 in 288
Hairdressers .....	1 in 62	Costermongers .....	1 in 323
Smiths .....	1 in 62	Artists .....	1 in 550
Chair makers .....	1 in 64	Plumbers .....	1 in 702
Postmen .....	1 in 64		

*Occupations of females (five years' statistics.)*

Box makers .....	1 in 32	Charwomen .....	1 in 103
Needle women, shirt makers and sewing machinists .....	1 in 36	Milliners and dressmakers.....	1 in 119
Fur workers .....	1 in 39	Artificial flower makers .....	1 in 126
School mistresses and teacners ...	1 in 68	Cooks.....	1 in 129
Book folders .....	1 in 75	Domestic servants.....	1 in 136
Cap makers .....	1 in 83	Nurses .....	1 in 192
Tailoresses .....	1 in 91	Laundresses.....	1 in 231

12. **Gaskoin, George.** — A rare case of skin disease. *Medical Times and Gazette*, April 24, 1875.

13. **Hutchinson, Jonathan.** — Skin disease in an infant. *Lond. Path. Soc. The British Medical Journal*, March 20, 1875.

14. **Piffard, Henry G.** — Periodical vesicular eruption following the bite of a rattlesnake. *Med. Record*, Jan. 23, 1875.

15. **Lagout.** — *Pneumonia herpetica*. *L'Union Médicale*, Nov. 8, 1875.

16. **Howard, J. M.** — *Epidemic Jaundice*. *British Medical Journal*, March 20, 1875.

17. **Greenhow, E. Headlam.** — On Addison's disease. *Lancet*, March 6, 13, 20, 27, and April 3, 17, 1875.

18. **Wright.** — Peculiar discoloration of the skin, accompanying affections of the kidneys. *Trans. Acad. of Med. The Clinic*, April 24, 1875.

The case reported by GASKOIN (12) is a singular instance of deviation from the ordinary types of skin disease. The eruption exhibited the peculiarity of occurring in the form of perfectly straight lines. The lines varied from one to eight or more inches in length, with a breadth of not more than three-eighths of an inch. They showed a decided tendency to spread, always extending by linear prolongations. In this manner they advanced over large tracts of the body and extremities. Upon the latter they preserved a direction exactly parallel to the limb. At times a number of perfectly parallel lines occurred in rather close proximity to each other. The fresh lines were red and shiny, looking as though the cuticle had been removed; soon vesicles made their appearance at the edges and extremities of the lines, followed by pustules, and in a few days desquamation occurred, leaving merely a slight discoloredation of the skin, without cicatrices. Scattered, simultaneously, over the body were several pustules of a phlyzaceous character. The patient had previously suffered

from some scaly eruption which was associated with purpuric spots. The linear eruption, while at its most inflammatory stage, was exceedingly sensitive. It is not stated how nearly the eruption followed the courses of the nerves, nor whether the cleavage lines of the skin appeared to have any influence upon the course of the eruption. A case is referred to, where a similar arrangement was observed, but which was at the time regarded as merely "a factitious urtication." This case was presented before the London Clinical Society, in November last, and was reported in the Medical Times and Gazette, December 12, 1874.

HUTCHINSON'S case (13) is very imperfectly reported. There was some cutaneous affection in which the skin became inflamed with the production of vesicles, peeling of the skin, scars and dark stains, and which appears to have been connected with derangements of the nervous system. The child's development was defective. H. had seen two similar cases before, following exposure to great cold.

In PIFFARD'S case (14) a young woman, while performing as a serpent-charmer in the "side-show" of a circus, was bitten on the thumb by a rattlesnake. She recovered from the injury, however, after some severe local inflammation, but singularly enough, at regular intervals, of about three months, a vesicular eruption made its appearance at the seat of the former injury, accompanied by contraction of some of the flexors of the hand. After remaining for a few days the eruption would disappear, not to return again until the usual interval had elapsed. For a number of years it occurred with regularity, but afterward the intervals became longer, and when P. last saw the patient there had been no return for seven or eight months.

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## DISEASES OF THE GLANDS.

LOUIS A. DUHRING, M. D.

1. **Botkin, S.** — Hyperhydrosis unilateralis, Berlin. *Klin. Wochenschrift*, No. 13, 1875.
2. **Bigelow, John M.** — Case of hyperhydrosis; cure. *New York Med. Journal*, June, 1875.
3. **Bryan, Alonzo.** — A case of unilateral sweating of the head. *The Clinic*, June 5, 1875.

4. **Botkin, S.**—Reflex phenomena and sweating. Berlin, Klin. Wochenschrift, No. 7, 1875.

BOTKIN (1) relates the case of a man who had been subjected to unilateral sweating for some thirty years, which was peculiar in that it was induced only by the process of eating. The regions affected were the right side of the face, including the greater part of the forehead, side of neck, and shoulder. The lower portions of the body were warmer and slightly moist during the taking of food, but not to the extent of the face. The sweat collected in large drops, the pulsation of the right temporal artery became prominent, and the skin became more or less hyperæmic. Irritation of the sympathetic by the induced current, provoked no attack similar to that caused by eating; although if the patient began to eat while the current was flowing, the sweat immediately appeared. Faradization, applied during the act of eating, caused decided improvement in the abnormal symptoms. The nervous system did not seem to be in any way deranged. The electro-sensibility of the right cheek was diminished, while the hearing of the man, which was imperfect, was worse on the right side.

BIGELOW (2) reports the case of a male patient, aet. 26, stout and apparently healthy, who had suffered from sweating of the feet for six years. The disease was severe, accompanied by an offensive odor (Bromo-hyperhydrosis), and was confined to the soles of the feet. Dr. B. states that he resorted to "Hardy's treatment as introduced by Hebra." In view, however, of the facts relating to the discovery of this very valuable treatment in this class of diseases, we should prefer to see the laurels placed where they belong, in this case upon Hebra rather than Hardy.

Dr. B. describes his dressing of the parts in the following manner: Diachylon plaster was cut into strips and wound around each toe, as well as being applied in a large piece to the sole; this was changed twice daily, and the skin carefully wiped with dry, heated flannel. The treatment was continued uninterrupted for 13 days, during which time the patient remained in bed. The result was successful, no return of disease reappearing up to the fourth week after the discontinuance of the remedy.

5. **Cheadle, W. B.**—Acne Rosacea. The Practitioner, July, 1874.

6. **Gamberini, Pietro.**—Compendiata monografia patologico-clinica delle glandole sebacee. *Giornale Italiano delle Mallattie Veneree e della Pelle*, Agosti, 1874.
7. **Wigglesworth, Edw., Jr.**—Affections of the sebaceous glands. *Boston Med. and Surg. Jour.*, Jan. 28, and March 18, 1875.
8. **James, Constantin.**—Acne. *Gaz. Med.*, No. 13, 1875.
9. Sweating of the feet. *l' Abeille Méd.*, No. 13, 1875.
10. **Duhring, L. A.**—Sycosis non-parasitica. *Phil. Med. Times*, No. 177, 1875.

CHEADLE (5) gives a very clearly written and concise paper, discussing the general features of this disease, with special reference to pathology and treatment. The distinction between acne and acne rosacea is carefully drawn, the ground upon which they are separated being entered into at length. Excellent results were obtained in the treatment of four cases by dry faradization of the parts.

GAMBERINI (6) presents quite an extended article in which seborrhœa, acne and lupus erythematosus receive special attention. The paper shows familiarity with the labors of German workers.

WIGGLESWORTH (7). In this paper the various diseases of the sebaceous glands are all briefly considered, a short description of each being presented, followed by directions for treatment, and especially external treatment, of which Dr. W. is a zealous advocate. The remedies recommended are chiefly those in vogue with the German school of dermatology, and consist for the most part of heroic or stimulating measures, soap and water playing a prominent and active part in the list. The article is intensely practical in tone, and is written in clear and unmistakable language.

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## INFLAMMATIONS; ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M. D.

1. **Abbott.**—Chronic erythema of the face. *Bost. Med. and Surg. Jour.*, May 20, 1875.
2. **Bristowe, J. S.**—Cases illustrating various forms of erythema and their relation with lupus, pemphigus and other affections. *St. Thomas' Hosp. Rep.*, vol. v, 1875.

3. **Coulaud, C.** — De l'Erythème papuleux dans ses rapports avec le Rheumatisme. *Archiv. générales de médecine*, Jan., 1875.
4. **Duffin.** — Erythema multiforme. *Med. Times and Gaz.*, Jan. 29, 1875.
5. **Smith, W. G.** — Erythema multiforme *Irish Hos. Gaz.*, May 1, 1875, p. 143.
6. **Auspitz, H.** — Changes in the circulation in urticaria. *Vierteljahr. für Derm., u. Syph.*, I Jahrg. Heft. II and III.
7. **Munchmeyer.** — Urticaria. *Berlin, Klin. Woch.*, May 12, 1875.
8. Mustard foot bath in Urticaria. *Trib. Médicale*, March 7, 1875. *Phil. Med. Times*, p. 488, May 1, 1875.

In a long and exhaustive series of observations upon the effects of artificial obstruction of the cutaneous circulation in certain diseases of the skin, under the title "*Ueber venöse Stauung in der Haut*," AUSPITZ (1) is led to the opinion that in urticaria we have a transitory functional disturbance produced by the reflex transmission of an irritation from sensitive to vasal nerves. It must be considered as undetermined whether we have here a reflex paralysis of the vasomotor nerves which contract, or a reflex irritation of those which dilate the vessels, as Goltz has suggested in his last publication (*Pflügers Archiv.* 1874.) The familiar experiments of Loven have demonstrated that stimulation of sensory nerves will produce dilation of the neighboring arteries; but it has been generally accepted that such transmission could be accomplished only by means of the central apparatus, although the investigations of Schlesinger and Goltz have shown that not only the medulla oblongata but the spinal cord also is to be regarded as the seat of vasal nerve-centres. Auspitz considers it not improbable, however, that such transmission may be effected by means of ganglia situated immediately in the skin and in direct connection with the blood vessels for the regulation of the circulation. On this supposition we may have produced in urticaria the transient and irregular dilatation of one capillary district with the complimentary contraction of an adjoining one through reflex transmission, without the interposition of the central apparatus. He attributes to the serous exudation, the essential element in urticaria, the varying shades of the wheal, the light color of its centre and the deeper of its edges, inasmuch as it covers the capillaries with varying shades of thickness.

9. **Bony, M.** — Herpès généralisé fébrile. Report of a case in Hospital de Besançon. *An. de Derm. et de Syph.*, Tome VI, No. 1.

10. **Bucquoy.** — Zona. *La France Méd.*, No. 32, April 21, 1875.

11. **Guie.** — Morphia subcutaneously in herpes (*La France Méd.*) *Phil. Med. and Surg. Reporter*, April 10, 1875.

12. **Kaposi.** — Herpes Zoster. Ein eigenthümlicher Fall. *Wiener Med. Wochenschr.* in *Vierteljahresschrift für Derm. und Syph.*, 1 Jahrg. 2 u. 3, Heft.

13. **Kaposi.** — On a second attack of bi-lateral zona (*Wien. Med. Woch.*) *Missouri Clin. Rec.*, p. 246, March, 1875.

14. **Rendu, H.** — Changes in the sensibility of the skin in zoster (*Recherches sur les altérations, etc.*) *An. de Derm. et de Syph.*, Tome VI, No. 2.

15. **Thompson, J. A.** — Herpes zoster treated with zinc phosphide. *Glasgow Med. Jour.*, Oct., 1874.

16. **Thomas.** — Abortive pneumonia with herpes analis. *Memorabilien*, p. 401, 1874.

17. **Wadsworth, O. F.** — An unusual case of herpes zoster ophthalmicus. *Bost. Med. and Surg. Jour.*, p. 224, Feb. 25, 1875.

KAPOSI (12) gives here a detailed account of a case of herpes, which was seated principally upon the right arm. The anomalies in it were: the peculiar method of development of the individual groups of efflorescence, circles of new vesicles constantly forming about the drying or crusted central eruption, after the manner of herpes circinatus, until the whole patch reached the size of a half dollar: the arrangement of the vesicles and crusts in the form of long streaks, which extended by the peripheral development of fresh vesicles: the peculiarity that these stripes and groups did not correspond in their long axis to the course of direction of the cutaneous nerves, but ran either transversely to, or crossed it more or less: the uniform progress of the eruption from the periphery of nervous distribution toward the nervous centre: the extension of the zoster across median line, and from the region supplied by the first and second intercostal nerves to that belonging to the third and sixth: and lastly the recurrence, eight weeks after the disappearance of the affection, of an eruption of exactly the same character. It was also remarkable that the new efflo-

rescences appeared in many places upon portions of the skin which were marked by pigment deposit as seats of the former attack.

In connection with a long series of observations upon the modifications of sensibility in the various affections of the skin here recorded, Rendu (14) expresses the following conclusions with regard to zoster: That there constantly exist, in zona, disturbances of sensation which are peculiar to it. No other affection, except it be pemphigus, which seems to him to be closely allied to zona, presents a similar combination of anaesthesia and hyperæsthesia, showing themselves simultaneously at points where the eruption is most intense. There is, in fact, a double phenomenon: On one side an inflammation of the skin, which manifests itself by hyperalgesia and hyperæsthesia; on the other, a neuritis, which produces in certain nervous filaments an augmentation of sensibility, in others, a temporary abolition of the power of sensation. This painful anaesthesia, as it has been called, is by no means a special phenomenon of zoster, but is met with in all neuralgias. It has been frequently observed in sciatica and facial neuralgia. In zona it is not, therefore, the result of the cutaneous efflorescence in itself, but of the neuralgia of which the eruption is only an "epiphénoménon." The study of the alterations of sensibility in zona furnishes, therefore, a new and indirect proof of the theory that both the cutaneous and neuralgic manifestations of the affection belong to the class of disturbances called trophic.

18. **Hutchinson, J.** — On the various skin eruptions classed as hydroa. *Lancet*, May 22, 1875.

19. **Besnier, M. S.** — Acute pemphigus. *Lyon Méd.*, p. 374. Nov. 22, 1874.

20. **Bourretere.** — Erysipelas of the face. *Thèse de Paris*, 1875.

21. Discussion on erysipelas. *Cincinnati Acad. of Med. The Clinic*, April 24, 1875.

22. Discussion on erysipelas. *St. Louis Med. Soc. St. Louis Med. and Surg. Jour.*, p. 265, May, 1875.

23. **Foster, Clarence.** — External use of tincture of iron in erysipelas. *Med. Times and Gazette*, p. 362, April 3, 1875.

24. **Handt.** — Erysipelas as a complication of leucocytæmia. *Le Progrès. Méd.*, p. 139, March 13, 1875.

25. **Renaut.** — Changes in the epidermis and rete Malpighi in erysipelas. *Arch. de Phys.*, No. 203, 1874.

26. Treatment of Erysipelas by camphorated ether. *Bull. gen. de Thérap.*, March 30, 1875.

27. **Bartels.** — Malignant pustule. (*Milzbrand beim Menschen.*) *Langenbeck's Arch.* 1874, in *Vierteljahr. für Derm. und Syph.* 1 Jahrg., 2 and 3 Heft.

BARTELS (27) reports the case of a girl 14 years old, who had upon the top of her right shoulder a carbuncle, which had developed from a small papule in five days. The skin was gangrenous, a centimeter in width, and near it was a vesicle filled with yellow serum. The upper part of the arm was swollen, doughy and purplish, but not painful. There was high fever and great restlessness. Twelve hours later the whole upper arm, the right half of the face and the upper part of the chest, front and back, were swollen, and the gangrenous spot had become three times as large and was surrounded by a circle of vesicles, but the painfulness was less. After free incisions and cauterization of the cut surfaces with fuming nitric acid, recovery was rapid.

The patient stated that, besides herself, three other persons of her acquaintance were affected in the same way. A boy fourteen days before herself, who died; a girl, a week before, who was still sick, and her brother, who recovered without treatment. In all of these the seat of the pustule was the face. All of them, with the exception of the brother, had been employed in picking horse-hair, of which they had considerable quantities to work upon in their houses, and which had lately been unusually dusty. The brother, although he had not worked upon it, had nevertheless been for a considerable time in the room while the picking was going on. Bartels concluded, therefore, that the infection was communicated by the horsehair (which might have been mixed with cow's hair), through the organs of respiration.

28. **Geber, Dr. Edward.** — On the nature of Aleppo boil. (*Ueber das Wesen der Aleppobeule.*) *Vierteljahresschrift für Dermat. und Syph.* 1 Jahrgang, 4 Heft.

Dr. GEBER, instructor in dermatology at Vienna, gives under the title, "*Erfahrungen aus meiner Orientreise*," a long description of the various forms of skin disease prevalent in the East, to which the name Aleppo boil has been applied. The natives understand by

it a chronic inflammatory affection of the skin, which finally heals with the formation of a scar. After a very careful and prolonged study of cases which were there regarded as unquestionable examples of the affection, and of which minute descriptions are given, he comes to the conclusion that no such special endemic disease exists, and that in the great majority of cases the cutaneous processes thus called are lupus, or the manifestations of syphilis or scrofula, which all prevail to a frightful extent in those regions, more or less modified in their course and appearances by climatic influences, ritual observances and peculiarities of race.

**29. King.**—Carbuncular inflammation of the upper lip. Am. Jour. Med. Sci., p. 154. Jan., 1875.

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## INFLAMMATIONS; CHRONIC; SQUAMOUS AND PUSTULAR.

GEORGE HENRY FOX, M. D.

**1. Jones, C. Hanfield.**—Cases of psoriasis. St. George's Hosp. Reports, Vol. VII, 1874.

**2. Squire, Balmanno.**—Internal administration of tar in psoriasis. Brit. Med. Jour., April 10, 1875.

**3. Anderson, McCall.**—Internal administration of tar in psoriasis. Brit. Med. Jour., April 24, 1875.

**4. Gubler.**—Effect of mercury in psoriasis and eczema. Jour. de Thérap., Dec. 25, 1874.

SQUIRE (2) of London, in order to test the relative value of tar internally and externally in psoriasis, experimented as follows: To one hospital patient he gave camphor mixture, with tar ointment applied externally, to the next he gave tar-capsules internally, pushing the remedy *ad nauseam*, and so on alternately with about thirty cases. At the end of two months the former had improved considerably, while the latter were, if any thing, worse than at first.

These cases, now being treated with tar externally, began speedily to improve. He concludes therefore that tar, taken internally, has no effect in curing psoriasis.

ANDERSON, (3) in reference to the above experiments, states that the results of his experience are strangely at variance with those of Mr. Squire.

Having used the remedy extensively for years, he regards it as one of the most valuable in the treatment of psoriasis, and has found it to yield satisfactory results in cases after long courses of arsenic, and many other orthodox remedies had been tried in vain.

5. **Mackey, E.** — *Lichen urticatus* — local treatment of. *Brit. Med. Jour.*, Dec. 26, 1874.

6. **Blachez.** — *De la dermatite exfoliatrice généralisée*. *Gaz. Heb.*, pp. 177 and 180. March 19, 1875.

7. **Gairdner.** — *Pityriasis rubra acuta* — recurring during seventeen years. *Brit. Med. Jour.*, March 13, 1875.

8. **Gailleton.** — *Pityriasis nigra* — case of. *Lyon Méd.*, Nov. 22, 1874.

9. **Guibout.** — *De l'herpétide maligne exfoliatrice*. *L'Union Méd.*, No. 154, 1874.

10. **Hutchinson, J.** — Case of the pityriasic variety of congenital xeroderma. *Lancet*, Jan. 23, 1875.

11. **Vidal.** — *De la dermatite exfoliatrice*. *Gaz. Heb.*, Nov. 12, 1874.

At a meeting of the Glasgow Pathological and Clinical Society, Dr. GAIRDNER (7) presented a patient recently recovered from an attack of pityriasis rubra. The case was described at its commencement by Dr. McGhie, in the *Glasgow Med. Jour.* for 1858 (Vol. V, p. 431). The invasions of the disease have lasted several months, and occurred at intervals of several years, during which time the patient states that he has enjoyed tolerably good health. The febrile character of the invasion overlooked or denied by many writers, was manifest in this case, the temperature rising as high as  $103.8^{\circ}$  Fahr. The effect of the constitutional derangement was seen in the nails which presented a deep transverse furrowing.

GAILLETON, (8) in presenting to the Société des Sciences Médi-cales a case of pityriasis nigra, remarked that as the disease had begun as a humid affection and recurred at more or less regular intervals, it would be diagnosed by Hebra as a chronic eczema. The case however presented quite a different aspect from the

ordinary form of chronic eczema, the cutaneous alteration consisting in an inflammation of the papillary layer, accumulation of pigment in the rete mucosum, excessive proliferation of the epidermis with an occasional eruption of vesicles.

In the discussion of the case he said that no modification of the urine had been observed, nor any indication of affection of the supra-renal capsules. He regarded pityriasis rubra and pityriasis nigra as pathologically identical, the lesions being a dry catarrhal inflammation of the papillary layer followed by a special cachexia, and the prognosis in either case of doubtful nature.

M. Horand regarded the case as a generalized eczema with accumulation of pigment in a subject with a dartrous diathesis since the disease evinced a tendency to attack the pulmonary membrane. In conclusion G. declared that it was neither a typical eczema nor a typical pityriasis, but one of that numerous class of abnormal skin affections. As to the nature of the cachexia he was in some doubt, not wishing to make "la darte" an asylum for all unknown cachexias accompanied by cutaneous manifestations.

12. **Duckworth, Dyce.** — Notes on Acne. Case of disseminate lichen planus; pemphigus diutinus, lichen ruber, etc. St. Barth. Hosp. Reports, Vol. X, 1874.

13. **Douaud.** — Inoculability of herpes and impetigo. Bordeaux Médical.

14. **Vidal.** — Inoculability of the pustules of ecthyma. Gaz. Hebdom., Feb. 13 and Nov. 20, 1874.

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## PARASITIC DISEASES.

HENRY G. PIFFARD, M. D.

### I. VEGETABLE.

1. **Malassez.** — Note concerning the fungus of pityriasis simplex. (*Note sur le champignon du P. Simple.*) Archives de Physiologie, July, September, 1874.

2. **Fox, T.** — Tinea decalvans and tinea tonsurans. Lancet, Vol. II, 1874, p. 510. Med. Times and Gazette, Dec. 5, 1874.

3. **Horand.** — Herpes tonsurans in animals. (*L'Herpes Ton-surant chez les Animaux.*) Lyon Médic., Sept. 13, 1874.

4. **Michelson.** — Transmission of herpes tonsurans from an animal suffering from h. tons. and scabies. (*Uebertragung von einem an Herpes, u. s. w.*) Berl. Klin. Wochenschr., Nos. 11 and 12, 1874.

5. **v. Veiel.** — The treatment of sycosis at the Cannstatt Hospital. (Ueber die Behandlung der Sycosis in der Heilanstalt zu Cannstatt.) Blätter f. Heilwiss. No. 11, 1873.

6. **Hawley, Hutchinson, Walker.** — Treatment of favus. Lancet Correspondence. Vol. II, 1874, pp. 332, 365, 436.

7. **Liveing.** — Alopecia areata and tinea tons. Med. Times and Gazette, Nov. 28, 1874.

8. **Smith.** — On favus. Dublin Journal of Med. Sciences, May, 1875.

9. **Neumann.** — On a combination of eczema marginatum with onychomycosis, and on parasitic sycosis. Med. Times and Gaz., Jan. 9, 1875, from the Wien Med. Presse.

10. **Vincens.** — Experimental researches concerning herpes tons. in animals. (*Recherches expérimentales, pour servir à l'Histoire de l'Herpes Tonsurant chez les Animaux.*) Paris, 1874.

MALASSEZ (1) collects the desquamated epithelium of simple pityriasis, soaks it in ether for two days to extract all fatty matters, then preserves in alcohol. Upon examination with high powers (Hartnack No. 10), finds quite long ovoid spores characterized by a peculiar constriction or neck at one end. The largest measure 4 to 5  $\mu$ . in length by 2 to 2.5  $\mu$ . in breadth; also round spores 2 to 3  $\mu$ . in diameter. No mycelium. In scalp sections he finds the spores upon the surface, also infiltrated among the cells of the stratum corneum, separating it into lamellae. The spores penetrate the upper part of the hair follicles, but are not found in the sebaceous glands. He regards the affection as essentially parasitic and employs twice a day frictions of the following:

R Turpeth mineral, 1 gramme. (gr. 15.)  
Cocoa butter.  
Castor oil.  
Oil of sweet almonds, about 20 grammes (grs. 300.)  
With soap and water twice a week.

(I have verified the microscopical observations of M., but must regard his conclusions as premature. — H. G. P.)

Fox (2) reiterates his belief in the parasitic nature of tinea decalvans, and suggests that it is allied to tinea tonsurans.

HORAND (3) as the result of some experiments upon the artificial inoculation of the parasites of favus and tinea tonsurans has arrived at the following conclusions:

1. The rat is refractory to the successful inoculation of herpes tonsurans, but favus will develop upon this animal with great facility.

2. The cat may contract both h. tons. and favus.

3. The dog contracts favus, but more easily herp. tons.

MICHELSON (4) found a whole family suffering from herp. tons., which he traced to infection from a cat, suffering from both h. tons., and scabies, upon microscopical examination he found the acarus of the cat covered with spores of the trichophyton. He gives wood-cuts of the appearances observed.

v. VEIEL (5) usually cures cases of sycosis in four weeks, by cutting the hairs short, removing crusts with scissors, and then rubbing in a mixture of two parts of tar and one of green soap. The hairs are then easily removed with forceps. After epilation he applies acetic acid, repeating the epilation if necessary. He finishes with sulphur ointment.

SMITH (8) reports several cases of epidermic favus.

VINCENS (10) believes favus and tinea tonsurans to be distinct diseases, depending upon different parasites, and never hybridizing; cites numerous instances of tinea tonsurans observed in calves and horses; quotes RAYNAL, to the effect that tinea tons may be transmitted from horse to horse, from cow to horse, and from horse and cow to man; quotes HORAND, who observed a case of trichophytic onychomycosis contracted from a dog. VINCENS made twenty-one inoculations of trichophytic matter upon eight rats, old and young, with negative results; made inoculations with same matter upon four cats, with two positive, one doubtful and one negative result; with same matter upon two dogs, both successful. He inoculated favus matter upon one rat and three cats with positive results in each case; upon two dogs without effect.

## II. ANIMAL.

11. Liveing.—Treatment of scabies. Brit. Med. Jour., Jan. 30, 1875.

12. Fox.—Treatment of scabies. Lancet.

13. **Clemens.**—Treatment of scabies. *Brit. Med. Jour.*, Feb. 27, 1875. (Allg. Med. Cent. Zeitg.)

14. **Bergh.**—Scabies crustosa. (Tilfælde af Skorpenat.) *Hospitals Tidende*, May and June, 1874.

15. **Heiberg.**—Leptus Autumnalis. *Nord. Med. Arkiv.*, VI, 25.

CLEMENS (13) uses in scabies, arsenic 1 part, carbonate of potassa 20 parts, soap-spirit 200 parts, and water 2,000 parts, rubbed into the affected skin twice daily.

BERGH (14) contributes several cases, with illustrations, of Norwegian itch. This article appears among the "original" contributions in the last number of the *Vierteljahrsschrift für Derm. und Syph.*, I Jahrg. Heft IV., 1874.

HEIBERG (15) discovered that the leptus autumnalis was the cause of an eruption which annually occurs (in the month of August), in the village of Thisted, Denmark. The affection usually appears upon the forearms and neck, and is at first papular, then vesicular and pustular, and is accompanied with intense itching. He treated it with local applications of the tincture of *Pyrethrum caucasicum*.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### GENERAL QUESTIONS IN SYPHILIS, THERAPEUSIS, ETC.

R. W. TAYLOR, M. D.

1. **Acton, W.**—On the prevalence and severity of syphilis among the troops in London and Paris. *Lancet*, April 24, 1875.
2. **Bailey, T. K.**—Ulcer upon the nates, probably of syphilitic origin. *Phil. Med. and Surgical Reporter*, April 10, 1875.
3. **Bailey, T. K.**—Ulcer upon the thigh, and disseminated indications of syphilitic disease. *Phil. Med. and Surgical Reporter*, April 10, 1875.
4. **Bremer, Victor.**—Syphilitic fever. (*Om Feber tilfäl de hos. syfilitiske.*) *Nordiskt Mediciniskt, Arkiv* 6, 1874, and *Gazette Hebdomadaire*, March, 1875.

5. **Balz, Dr.** — Hemorrhagic syphilis. (*Ueber hämorrhagische Syphilis.*) Archiv der Heilkunde, February, 1875.
6. **Dowse, Dr.** — Syphilitic ulceration of the rectum. Lancet, February 6, 1875.
7. **Erasmus, P.** — Clinical studies in syphilography. (*Studii Clinici di syphilografia.*) Giornale Italiano della mal. Ven. e della Pelle, No. 5, 1874.
8. **Farnsworth, P. J.** — Variola and secondary syphilis. Cincinnati Med. News, December, 1874.
9. **Farquharson, Dr.** — Haemoptysis in a syphilitic patient. Lancet, January 16, 1875.
10. **Gascoyen, G. G.** — Cases of syphilitic reinfection. Med. Times and Gazette, December 5, 1874.
11. **Gross, S. G.** — Syphilis in its relation to national health. Louisville and Richmond Med. Jour., January, 1875.
12. **Henry, M. H.** — Three cases of induration of the os uteri, the result of syphilis. Am. Jour. of Syph. and Derm., Oct., 1874.
13. **Hyde, J. Nevins.** — On the contagious disease of the silk worm, and its analogy to syphilis in man. Chicago Med. Examiner, July 15, 1874.
14. **Janovsky, V.** — Contributions to the study of syphilitic fever. (*Beiträge zur Lehre vom syphilischen Fieber.*) Vierteljahr. für de pract. Heilkunde, Vol. CXX, 1874.
15. **Kaposi, M.** — The diagnosis of constitutional syphilis. (*Zur Kenntniss der allgemeinen Syphilis.*) Wiener Med. Presse, No. 4, 1875.
16. **Kohn, M.** — Clinical and histological character of the syphilides. Richmond and Louisville Med. Journal, January, 1875. Translation by E. Von Donhoff.
17. **Laroyenne.** — Sterility originating in syphilis. (*De l'Infécondité d'origine syphilitique.*) Lyon Médicale, No. 4, 1875.
18. **Lewin, S.** — Syphilitic infection without coitus. (*Ueber infectis sine coitu.*) Viertel. für Derm. u. Syph., Nos. 2 and 3, 1874.
19. **Petit, L. H.** — Syphilis in its influence upon traumatism. (*De la syphilis dans les rapports avec le traumatisme.*) Brochure, Paris, 1875.
20. **Sturgis, F. R.** — Criticism on a so-called case of infection by syphilitic semen. Phil. Med. Times, February 6, 1875.

21. **Southey, Reginald.**—Bright's disease in a syphilitic subject. *Transactions of Clinical Society of London*, 1874.
22. **Taylor, R. W.**—The relation of syphilis to health and to life. *Medical Record*, March 13, and April 17, 1875.
23. **Taylor, R. W.**—The question of the relation between rachitis und syphilis. *American Practitioner*, Feb., 1875.
24. **Thompson, W.**—Tertiary lesions of syphilis. *British Medical Journal*, March 13, 1875.
25. **Turner, Robert.**—Case of non-syphilitic rupia. *Lancet*, Feb. 6, 1875.
26. **Venning, M.**—Secondary syphilitic disease occurring 23 years after infection. *Med. Times and Gazette*, Jan., 1875.
27. **Weber, F.**—On the influence of syphilis on pregnant women under various modes of treatment. *Allgemeine Med. Central Zeitung*, Feb. 3 and 6, 1875.
28. **Zuppulla, Dr.**—Remarkable case of syphilitic stricture of the rectum. (*Observation remarquable de retrécissement syphilitique du rectum.*) *Annales de Derm. et de Syph.*, No. 4, Vol. 5.

BREMER (4) made thermometric observations upon 44 syphilitic patients. He thinks that in early syphilis the temperature is higher than would have been supposed. In 19 cases in the first stages of constitutional manifestation, the average range of temperature was below 100.4° F. In 12 it maintained an average between 100.4° F. and 102.2° F., while in 5 it was between 102.2° F. and 104° F., and in but one beyond this even. In the rather late stages the fever was less constant, for out of 25 it remained quite regularly under 100.4° F., in one case only reaching 104° F. upon two occasions. The duration of the fever was usually short. It commonly presented slight morning remissions, but, in some, the fall of temperature occurred in the evening. Bremer did not meet with an instance of the intermittent form which has been described by others. There was no acceleration of the pulse in his case, and the other usual febrile symptoms were wanting. B. thinks, being at variance in this point with others, that anti-syphilitic remedies have no power in reducing the temperature in syphilitics.

It may be interesting and appropriate here to give, in brief, the result of the observation of the reporter in 62 cases, in which the temperature was taken daily for long periods. These obser-

vations were made five years ago, principally at the New York Dispensary, and were not published owing to the difficulty in presenting, in a clear manner, such a vast series of figures. The reporter, in several instances (6), noticed a rise in the temperature at periods of between two weeks and six days before the evolution of secondary manifestations. In some cases it was noticed that, at the period of evolution of these manifestations, the temperature rose abruptly to  $103^{\circ}$  F., remaining at that figure for a week or ten days, then subsided and remained at  $100^{\circ}$  F. for several months. In only one case did the reporter observe as high a range of temperature as  $105.4^{\circ}$  F. This was the case of a woman, who, having a huge syphilitic induration of the left labium majus, presented an intense and persistent roseola and very early double iritis. Her temperature ranged between  $104^{\circ}$  and  $105.4^{\circ}$  F. for two weeks, then gradually declined and remained at  $102.2^{\circ}$  F. for some months. In her case a somewhat curious feature was observed, which was also noticed in some other cases, namely, that coincidently with the evolution of a relapsing syphilide, or with the occurrence of rheumatoid pains, her temperature would rise quite abruptly to the extent of two degrees and a fraction, but would descend one degree, and perhaps two, after a few days of treatment. In several cases of iritis there was a simultaneous rise of one or two, in very severe cases about three degrees. The persistence of the fever was noted to be variable; in some instances the normal temperature would be reached soon after the evolution and disappearance of secondary manifestations; in others, the elevation would persist for three and four months. In these cases the average range would be about  $100^{\circ}$  F. In some cases, particularly in those in which the constitution was robust, there was, at no time, any elevation of temperature whatever, while in weak and cachectic persons it, as a rule, followed a high range. As to the sexes it was noted that, all things being equal, the range of temperature in syphilitic women was about one-half of a degree higher than in men. After the third month of the secondary period a normal course may be noticed, but it often occurred that slight elevations co-existed with relapses. In the latter event the temperature was high or low in proportion to the extent of the lesion and severity of constitutional disturbance. In certain cases in which a severe cachexia was induced, the average range of temperature for long periods would be as high as  $102^{\circ}$  F., and as low as  $100^{\circ}$  F. and a fraction. In children it was noticed that a similar elevation was observed, but there was

nothing peculiar in the course of their temperature. In some isolated cases of very late secondary and of tertiary lesions, a slight elevation of temperature was noticed, but in general it may be stated that in such cases the temperature is normal. In two instances a marked difference in the evening as compared with the morning temperature was noted, in one instance the variation being three, and, in the other, two and one-fifth degrees. It was noticed by the reporter that mercurials did reduce temperature in a slight degree, but quinine was found to be powerless. It is intended to present these observations in full at some future day.

FARQUHARSON (9) read a paper before the clinical society of London on haemoptysis in a syphilitic subject. The patient was a soldier twenty-one years of age, the date of whose initial lesion was not known, but who was treated in a hospital in 1874 for anal condylomata and angina. In July he began to suffer dyspnoea upon exertion, and had a cough with expectoration, at first mucoid, then of a reddish tinge, and finally it was streaked with blood. In August he appeared sallow and earthy, no general constitutional disturbance was present, and no abnormal physical signs were heard in the chest. He was kept in bed, fed with ordinary diet, and a mixture of iodide of potassium and bi-chloride of mercury was administered. In twelve days his cough, which had been attended with the expectoration of a tenacious, slightly foetid and bloody mucus, ceased and his health improved. He has since been quite well and strong. Farquharson says that an isolated case like this might appear unimportant, but as it was one of a series presenting similar characters, it was valuable as elucidating disorders of the lungs produced by syphilis, which always yield to anti-syphilitic treatment. Farquharson thinks the lesion is an exudation into the minute bronchial tubes of a tissue similar to that of condyloma; from this blood exudes into the air vesicles, and produces cough. Anti-syphilitic remedies act by causing absorption. In reply, Dr. Southeby thought such cases not rare in syphilis, and that violent haemoptysis was often the first sign of that disease. In such cases he had observed that the blood was of a dark red instead of a bright red color as in phthisis, and that there might be no physical signs in the lungs, except absence of the vesicular murmur over the parts involved. He thought it probable that the exudation was in the air vesicles and not in the small bronchi in many cases, and that the pathological condition giving rise to it was thrombosis of the pulmo-

nary veins, as this accident occurs not unfrequently in syphilis. In reply to an inquiry by Dr. Buzzard, whether the temperature was observed, Farquharson stated that it was normal. Our insufficient knowledge, and the obscurity of these cases, render their study very interesting.

GASCOYEN (10) read a paper on reinfection by constitutional syphilis, before the Royal Medical and Chirurgical Society of London. He detailed eleven cases, seven of which he had treated for both attacks. Ten of these patients had previously had general syphilis, six had manifestations a second time, while in four an indurated chancre was the only lesion upon which to base the diagnosis. In the last case a well-marked, indurated chancre and inguinal adenopathy constituted the first disease, while the second was manifested by hard chancre and tertiary lesions without any secondary affections. (Unfortunately, full information is not given as to what form of tertiary lesion was observed.) The author thinks that syphilitic reinfection is not as rare as it is thought to be, and showed a table of sixty cases, including his own. The important fact that most of these cases had undergone a full mercurial treatment is stated. Gascoyen expresses somewhat peculiar views as to the indurated chancre. He considers it not a local affection, but rather the first of secondary manifestations—the earliest development of constitutional contamination. In most of his cases he says that the chancre followed intercourse at once, and the author considers that a period of incubation is not necessary. He explains this by the nature of the lesion from which the chancre originates. If developed from a chancre freely suppurating, the evolution is immediate and is pustular in form; if from an indolent chancre, a period of incubation elapses and the chancre begins as a papule. (It is evident that the author here means soft and hard chancres, both of which he seems to think are followed by syphilis. He, however, does not clearly express himself.—REP.) When resulting from secondary lesions, a chancre has a period of incubation. Gascoyen supports his view that a non-suppurating, indurated chancre is a secondary manifestation, by the fact that the lesion is identical whether it results from the secretion of a hard chancre, or of some secondary affection of the blood. He thinks that reinfection shows the relation of lesions to syphilis. In six of the cases, one being his own, tertiary lesions were present at the time of reinfection, consequently, he assumes that they are sequelae

rather than manifestations, since it is impossible to believe that two attacks can take place in the same person at one time. H. Lee, in the discussion, alluded to two cases which he had published. He thinks that the character of the second sore is different from that upon a previously healthy person, it being smaller, running its course quickly, not having such a long period of incubation as at first, and the glands not being so much enlarged, and suppurating occasionally. The secondary lesions, after reinfection, are milder though similar in character to those of the first outburst, and they yield more readily to treatment. He is unable to draw a distinct line as to the passing off of syphilis, but compares it to vaccination. In a case treated by him in which secondary manifestations were mild, reinfection occurred seventeen years later. In the second attack there was a small pimple with enlarged suppurating glands, followed by a copper-colored eruption. Lee also seemed to regard as an instance of reinfection, a case in which there was general enlargement and suppuration of the glands. Mr. Acton doubted the frequency of reinfection, and stated that recurring induration did not, in all cases, indicate a second attack of syphilis. Gascoyen's paper is open to the same serious objection which applies to those by other authors, notably one by Köbner, published several years ago. In their anxiety to swell the number of their cases, reporters admit instances which, to say the least, are dubious. Too much stress is laid upon recurring indurations upon the penis, which not unfrequently occur in the course of an attack of syphilis, and ephemeral engorgements of ganglia, as indicating a new or second attack of syphilis. The truth is that if the cases now recorded as showing reinfection of syphilis were critically examined, very many of them would be cast aside as worthless. It is to be hoped that, in future, all cases requiring straining of argument or unusual credulity will not see light. By this course, in time, we shall have clearer ideas upon this important but still unsettled subject.

HENRY (12) gives the history of three cases in which there was an engorgement of the os uteri, which he thinks was due to syphilis. The women had been infected with syphilis respectively two, eight and nine years, and besides other affections, complained of symptoms of general or local enlargement of the womb, such as pains in back, loins and thighs, and bearing-down sensations accompanied with leucorrhœal discharge. Prior to contagion they had no symptoms of uterine disorder. Upon examination

the os was in each instance found to appear enlarged and irregular in circumference, and to the touch a hard and dense doughy sensation was communicated. In one instance there was slight anteflexion. Under a mixed treatment alone the enlargements were rapidly reduced in size and the symptoms were cured. The author is not as explicit as we should desire him to be as to the nature of the lesion. He says of it: "I do not for a moment hold that, in the cases I have reported, there was a local collection of specific syphilitic products or elements, such as we sometimes find in the connective tissue structures (the gummata). Still they were not cases in which the inflammatory condition could be said to be merely influenced by the syphilitic poison in the system, but rather to be looked upon as the direct results of its action, being produced and kept up by it alone." The practical suggestion offered by these cases is that some cases having this condition and symptoms in which an anterior syphilitic infection is well established, it would be worth while to try the effect of an anti-syphilitic treatment. The matter is certainly of sufficient importance to warrant a careful and extended inquiry into the correctness of the author's claim.

LAROYENNE (17) calls attention to the difficulty in assigning the cause of infecundity of women who, remaining perfectly healthy, and presenting no uterine lesion, hold marital relations with husbands who became syphilitic some years previous to marriage, and who do not present any special lesions to account for their sterility. He speaks particularly of having seen five such cases, the husbands having become syphilitic severally three, six, seven, twelve and fourteen years previous to marriage. He specifies the lesions of four only. One had the early exanthemata and osteo-periostitis, a second suffered from loss of both nose and ear, a third had paralysis of two cranial nerves, while a fourth had severe ulcerations of the leg, and it was thought that he had an orchi-epididymitis. Examination of the genitals of these men did not reveal any abnormality, still, though they had healthy wives, they did not have children. It is stated that they were not properly treated. Laroyenne does not venture a clear explanation, but leaves it greatly to inference. Alluding to the fact that in three out of five cases of fibrous orchitis, spermatazoa were not to be found, he appears to think that a similar or somewhat similar process takes place in these syphilites, even that limited gummosus infiltrations may occur, and yet

in practice they escape detection. Such hyperplasiae, according to L., sometimes do occur and produce symptoms so slight as to pass unperceived. Insufficient treatment is thought to have an influence upon the development of this condition. In the discussion of this paper before the National Medical Society of Lyons, Dr. Meynet made the pertinent suggestion that all such cases must be considered incomplete until full particulars are given as to the condition of the genital organs. He further thought that the cases reported did not warrant the conclusions drawn. M. Fochier alluded to the absence of microscopic examination of the sperm. M. Mollière recalled the fact observed by Liégois, that spermatozoa were present in the sperm of old syphilitics. H. Coutagne said that he had treated a man for syphilis who afterward married, and his wife remained without children. Examination of the semen of her husband showed the absence of spermatozoa. In answer to all objections, Laroyenne very justly and pertinently said that the coincidences which he had presented were peculiar. This certainly is a subject as yet little studied, but still one in the highest degree important in its therapeutical bearing, as well as in its relation to the perpetuation of the species.

LEWIN, (18) in a paper read before the Berlin Medical Society, detailed a series of cases, some of which were examples of syphilis contracted without coitus, while others presented interesting points relating to certain questions in hereditary syphilis. The first group consisted of two women and their offspring. The first, unmarried, having general syphilitic manifestations, also had an indurated nodule of the size of a bean on her lower lip. The second woman, married, presented syphilitic manifestations, and an indurated nodule on the nipple. Various facts proved conclusively that the contagion of syphilis occurred in one by the lip, in the other upon the nipple. The first woman noticed a small sore upon her lower lip at the seventh month of her pregnancy, her lover also having sore lips. Her child was born somewhat prematurely, and it was covered with a rash and was sickly. The second woman had given birth to three healthy children, and eight months after her last confinement she had given the breast to a strange infant. Three weeks later she noticed the ulcer.

The child of the woman infected at the seventh month presented the following symptoms: general weakness and emaciation, swell-

ing of the superficial ganglia, evidences of a maculo-papular eruption, induration of the right testicle, infiltration into the subcutaneous tissues of legs.

The second child was infected when eight months old. It presented a typical indurated chancre of tongue, swelling of the submaxillary and sub-mental glands, and a maculo-papular eruption. Lewin thinks that these cases prove, first, that syphilitic infection may occur at any part of the skin or mucous membrane; second, that children born of mothers infected at the seventh month of pregnancy, or late in that process, may present tertiary lesions or may even be healthy; third, that failure to find evidences of syphilis upon the genitals of the mother, does not prove that contagion resulted from the father; fourth, that women in the secondary stage may give birth to children presenting tertiary or more advanced lesions; fifth, that the symptoms of the hereditary disease have a greater intensity than those have which result from infection at birth, or shortly afterward; sixth, that tertiary or more advanced lesions may develop in cases in which mercury has not been given; seventh, that the child of the mother infected by the labial chancre presented the interesting question, i. e., to which parent did it owe its disease. Lewin thinks that the father infected the embryo by means of seminal fluid at the time the mother was contaminated. (This hypothesis, it may be added, is strained and should not be loosely accepted, as it is not supported by well-known facts as to syphilitic contagion.—REP.) Eighth, that hereditary syphilis, which has been fully manifested, may gradually pass into a latent condition which may extend over a period of years. Lewin supports this last proposition by a second group of cases, composed of a mother, two daughters and a grandchild. The mother had had two children, and had been perfectly healthy until her twenty-fifth year, when, in consequence of suckling a syphilitic child, she contracted a chancre upon her nipple. Her husband and child also became syphilitic. The three were well treated by mercury, but after a few months the strange child died. The mother and her child suffered severely, but afterward apparently recovered. Her husband became syphilitic, and finally died of some cerebral affection. Subsequently the woman was married to a healthy man who, soon after, had angina and rheumatoid pains. The syphilis in the wife again manifested itself in a severe form after her marriage. She gave birth to a syphilitic child, which died when five and a half months

old. A second child was born and still lives. She was said to be healthy until her sixth year, when a pustular eruption developed. This was cured by mercury, but in two years ulcerations appeared which underwent relapses in a gradually milder form. When cured of the trouble she presented no lesions, except a general adenopathy. The history of the sister who was infected from the mother's nipple is important. There was evidence of extensive ulceration in the throat. In her sixteenth year she had lupus (sic) upon the right thigh, as well as periostitis upon the tibiæ and frontal bone. This girl married when seventeen, but her husband died shortly after. She was again married and by the second husband she bore a child, which had, first, lichen scrofulosorum, second, an ulcer upon the right thigh having a syphilitic appearance, third an infiltration into the subcutaneous tissues over the right instep, and enlargement of the bones. Lewin draws the following conclusions: first, that in the organism of the female the syphilitic influence may remain in her system in a persistent manner, not compromising the intra-uterine life of her offspring, but engraving upon it a morbid condition which may remain latent for years; second, that syphilis, in some instances, may be inherited from the mother alone. The third group consists of a fifth child. Its mother went to the hospital in February, 1871, for syphilitic affections of the genitals and throat, where she was delivered of a still-born child. Three years before she had borne a healthy child. She was treated by mercurials and seemingly cured. Two years later she was delivered, rather prematurely, in the hospital, of a child. She had, in the meantime, suffered from ulcers upon the legs. Her child showed evidences of syphilis, with a peculiar affection of the base of the nail. The last three children having been vaccinated with humanized lymph, the vesicle ran in each a normal course, and the fluid taken from them did not present any appearance differing from that of healthy vaccine lymph. Lewin's paper is somewhat too lengthy, and, in one or two instances, matter rather too elementary is introduced, yet the details as to the course of hereditary syphilis which have been given are well worthy of careful study, as the facts now in our possession are too few, and in some instances not clearly enunciated.

PETIT (19) calls attention to a subject which, though cursorily treated of in some of the text books, has not as yet been considered in a systematic manner. His brochure is the elaboration of cer-

tain views held by Verneuil as to the influence of the syphilitic dyscrasia or diathesis upon various lesions of traumatism. The latter surgeon has, for many years, paid especial attention to the bearing of such morbid conditions as malaria and alcoholism, and also pregnancy upon the various traumatic lesions, and his conclusions have been both suggestive and instructive. The present work, then, embodies the views and is founded, in a measure, upon the cases of the accomplished Parisian surgeon, and as such commands more especial attention. At the end of the work Petit reduces his thesis to conclusions which give, in brief, an epitome of the work:

1. In subjects affected with severe syphilis, or who, in an ordinary syphilis, have not yet followed treatment, or have been but indifferently treated, traumatic lesions may present a peculiar aspect, or be attended with an abnormal course.
2. They present these characters either immediately after the wound, or a few days or weeks after, or even several months later.
3. This aspect varies. Sometimes the wound becomes a true syphilide; in others it ulcerates without assuming the syphilitic appearance, and does not heal; in others, finally, without ulceration, it does not cicatrize or does so but slowly.
4. When syphilitic lesions exist at the time of receipt of the wound, the latter assumes an appearance similar to that of syphilitic ulcerations in process of evolution.
5. Traumatism supervening in syphilitics in whom the diathesis is in a latent condition (the contagion being more or less remote), may induce syphilitic manifestations which are seated upon the wounded parts (local manifestations), or at a point more or less remote from this region (manifestations at a distant point), or upon a surface more or less extensive (general manifestations).
7. These manifestations or lesions are induced as readily in the tertiary as in the secondary period.
8. Syphilis may localize itself in a region previously free from any of its accidents, either primary, secondary or late, which has been the seat of a traumatic lesion.
9. The syphilitic affection would then be either an ulceration, which would destroy the cicatrix, or a tumor, which would follow the usual course of a gumma.
10. Once developed, traumatic syphilitic affections have most generally the same characters, and are cured by the same treatment as are its natural manifestations.

11. In certain cases, syphilis seems to be the determining cause of the complication of wounds.

12. These complications are also capable of inducing syphilitic manifestations.

13. In the beginning, the specific nature of traumatic syphilitic affections and the complications of wounds is, in general, rather difficult to recognize, as sufficient information is almost always unobtainable; but when it is observed that a wound assumes an ulcerating appearance, or shows no reparative tendency, and without presenting the features peculiar to another diathesis (sic), it is well to bear in mind the possibility, and to administer a treatment appropriate to that disease.

14. Previous to the performance of an operation which is not urgent, in particular autoplastic surgery, in a patient who, a short time before, had presented syphilitic manifestations, it would be prudent to prescribe mercury or the iodide of potassium.

15. In the event of a failure of this operation, it is well to wait for some time, and to place the patient again under treatment, and not to operate until at least six months after the disappearance of syphilitic manifestations.

The work is certainly a creditable production, and a perusal of both its cases, and its commentary, will suggest a number of practical points.

TAYLOR (24) alludes to the erroneous statement made by several authors, that rickets may be caused by syphilis. He shows that, by many, a pathological link is supposed to exist between the two diseases. Against this view he brings the facts that the lesions of the two diseases are, if carefully examined, totally different in appearance and nature, and that a treatment beneficial to one is harmful to the other. Thus, if rickets were caused by syphilis, a remedy for the latter disease would cause the disappearance of the osseous lesions of the former, but in practice such does not occur. Then, again, the general conditions are shown to be entirely different. He also alludes to the clinical fact that, when rickets does occur in syphilitic children, it is generally at a time when the syphilis is well advanced or nearly run out, or at an age when it might be expected to develop in any child. He concludes that, when rickets does occur in a syphilitic subject, it is either a coincidence, or that the disease may have been more or less remotely superinduced by the cachexia caused by syphilis. So that, according to this view, there is no specific

relation between the diseases; but the rickets, if induced by the general cachectic condition resulting from syphilis, bears the same relation to it that it would to any condition of debility or adynamic influence.

WEBER (28) gives the results of his observations upon 129 pregnant syphilitic women, treated in the Obervuchow Hospital, St. Petersburgh, during the ten years 1863-1873. As this paper is well abstracted in the British Medical Journal (January, 1875), we reproduce it here with slight change and comment. Of these patients 35 were treated locally, or, in other words, not at all; 35 were submitted to inunction treatment; in 23, inunction was combined with the external use of iodine (iodide of potassium with tincture of iodine); 19 were treated by the internal use of a combination of iodide of potassium and corrosive sublimate, and in 17 cases the iodide alone was used. Weber gives abundant statistical details, and sums up his conclusions as follows:

1. In general the course of pregnancy was interrupted in 25, or twenty per cent of the cases. This proportion, however, may be reduced, when it is remembered that four of the patients had erysipelas of the head, one recurrent fever, and one the typhus fever.
2. Every method of treatment which interferes with the digestive system, predisposes to untimely birth.
3. In the cases submitted to simple local treatment there were twenty per cent of premature births; in three, however (suffering from adynamic fevers and abscesses), violent fever appears to have been, in part, the cause of premature birth.
4. In the women who were treated by inunction, together with local remedies, there was no disturbance with the course of pregnancy. This confirms Sigmund's conjecture, that the inunction treatment has no injurious influence on the course of pregnancy.
5. In women in whom inunction was either accompanied or followed by the internal use of iodide, the percentage of premature births was 37. This, however, may be reduced to 20 by deducting two severe cases of erysipelas of the head.
6. General treatment with a solution of iodide of potassium and per-chloride of mercury, was attended with 15 per cent of premature births.
7. In cases treated by iodide of potassium, 42 per cent of untimely births occurred.
8. The injurious action of general treatment did not, in any

way, correspond to its duration, but much rather to its effects on the digestive organs. Hence, general treatment should be interrupted on the first indication of indigestion in a pregnant woman.

9. The period of pregnancy at which general treatment is commenced, appears to have no influence on the occurrence of premature labor.

10. The stage of development of the syphilis seems to be not without influence on the occurrence of untimely birth.

11. The puerperal period ran an abnormal course in four out of fourteen cases treated locally; in three out of eight, treated by inunction and iodine; in three out of four, treated by iodine and sublimate (one of these patients died), and in four out of ten, treated by iodide of potassium. It may be added that the avoidance of gastro-intestinal trouble in pregnant women under a mercurial treatment is of vital importance, and cannot be too clearly borne in mind. As regards the conclusions on the comparative treatment instituted by Weber, it must be confessed that his results are somewhat disappointing. It seems questionable whether any benefit results to the patient or to science, in the way of statistics, by the administration of iodine internally in these cases. Stripped of all the obscurity cast upon this subject by this (we must confess) not clearly drawn out mass of statistics, the matter revolves itself into the conclusion that pregnant women are benefited by mercury, either alone or in combination with the iodide of potassium. That either or both of these remedies should be given in full doses and for a long period, and that great precaution should be taken that, while the full therapeutic effects are produced, any thing like toxic action should be avoided.

#### CHANCRE AND CHANCROND.

1. **Barie, E.** — Multiplicity of simple chancre in woman (*De la multiplicité, etc.*). *An. de Derm. et de Syph.*, No. 5, 1874.

2. **Bardinet.** — Syphilis communicated by the finger of a mid-wife (*Syphilis communiquée par le doigt d'une sage-femme*). *Annales D'hygiène pub. et Méd. Légale*, July, 1874.

3. **Daffner, Franz.** — Pathology and treatment of chancres (*Ueber die Pathologie und Therapie des Schankers*). *Inaug. Dissertation, Munich*, 1874.

4. **Dron.** — Transplantation of skin upon a syphilitic chancre (*Observation de Greffes épidermiques sur un chancre syphilitique*). *An. de Derm. et de Syph.*, No. 4, 1874.

5. **Henry, M. H.** — Four cases of chancres in anomalous localities. *Am. Jour. Syph. and Derm.*, Oct. 1874.
6. **Kaszlinski, Franz.** — Excision of chancre (*Ueber Excision der Schanker*). *Inaug. Dissert.*, Greifswald, 1874.
7. **Lawson, R.** — On the influence of the contagious diseases acts on the primary venereal sores. *Medical Times and Gazette*, Dec. 26, 1874.
8. **Mason, Francis.** — On infecting sores of the lips and in other anomalous positions. *St. Thomas' Hosp. Rep.*, vol. 4, 1874.
9. **Schwartz, C.** — Syphilitic chancre of the os uteri (*Une observation du chancre syphilitique du col*). *An. de Derm. et de Syph.*, No. 1, vol. 6.
10. **Venot, Dr.** — Two cases of cephalic chancroid (*Deux cas de chancre mou céphalique*). *Bordeaux Médical*, April 4, 1875.

BARIE, (1) alluding to the fact of the multiplicity of chancroids, shows that in the female statistics prove that in one-fifth of a given number of cases the lesion will be unique, while in the balance there will be more than one; sometimes the number being very large. In a series of observations, made in the service of Fournier at Lourcine, out of 170 women having chancroids, in 134 the number of ulcers was variable, and in 36, or one-fifth, it was unique. In some of the cases the number of chancroids was extremely large; in one case there were 75 to be found. He alludes to the peculiarities of conformation of the female genitals and of the want of cleanliness as being the causes of the multiplicity.

BARDINET (2) was appointed by the local authorities to investigate the causes and nature of an epidemic, which appeared in the town of Brioë, France. He ascertained that those affected were parturient women (or their relatives, such as husbands and children), who had been attended at child-birth by a certain mid-wife. Upon investigation and examination of her, it was found that in February, 1873, she had had an ulcer on the border of the nail of the right middle finger, which was afterward followed by syphilitic manifestations. The syphilitic chancre upon the finger was very obstinate to treatment, and continued in an ulcerated condition, somewhat strange to say, until the following October. In the meantime, she had attended, according to her statement, fully fifty women in confinement. It was only determined that

fourteen women were infected by her with syphilis, though it was suspected that others were likewise affected, and that they concealed the fact from motives of shame and secrecy. The following are the facts: Between February 28 and March 15, she cared for three women, who became syphilitic. Between the latter date and June 28, though she attended a number of women, no cases of syphilis could be ascertained to have occurred. From this date, until October, she attended fifteen more women of whom only one escaped syphilis. It is suspected that in the interval of six weeks during which no cases of infection were noted, such did really occur, but as said before, that they were hushed up; again it is thought that perhaps during the period, or a part of it, the digital ulcer did not yield an infecting secretion owing to the applications which were then made. Eight of the husbands of the fourteen women, who thus became syphilitic, were also infected, as well as nine infants. Of the latter four died of syphilis. Thus we have a total of thirty one cases of syphilis, caused by one woman, out of which there were four deaths. It is thought, however, that the true number is nearly one hundred. The fact of the contagion having originated from the woman's finger is very clearly established; but in several of the children it must be confessed that the syphilis underwent a rather early evolution. In young subjects, however, this phenomenon is sometimes observed. The conduct of the woman cannot be commented on too severely, for she evidently knew of the serious nature of the disease which she was communicating, yet her cupidity incited her to continue her duties. She was found guilty and sentenced to a mild fine and two years' imprisonment. The practical suggestion of these facts is obvious.

Under the title "upon the pathology and treatment of chancre," DAFFNER (3) publishes a brochure, which we find to be a reprint from the *Aerztlichen Intelligenzblatte*. The same author not long ago published a small work upon genito-urinary diseases, in which, in a very unskillful manner, he treated of facts well known to a second course medical student, and in such a way as to give the impression that he was offering original matter. There is not a single new fact or idea in this book of twenty-eight pages, nor is there even a therapeutic hint therein contained worth remembering; the truth is, that well-known facts are not even well stated.

DRON reports (4) the case of a man having a syphilitic chancre upon his penis, which showed no tendency to cicatrization. He

therefore removed two small pieces of skin at a level with the papillary layer from the thigh, which he placed with proper appliances upon the ulcer. In eighteen days full adhesion and cicatrization took place. As a therapeutic procedure this treatment is so much limited as to be scarcely, if ever, required, but the interesting fact suggested by the observation is that adhesion and reparation should occur under the circumstances. There was no possible doubt of the syphilitic nature of the ulcer.

HENRY (5) reports four cases of extra-genital syphilitic chancre. In the first and second the ulcer was seated on the lower lip; in the third upon the malar prominence resulting from a bite; and in the fourth on the back of the hand over the fourth and fifth metacarpal bones. He thinks that syphilitic chancres situated at parts more or less remote from the genitals are of less frequent occurrence in this country than in others, since he has met with but four instances in seventeen years. This he attributes to the absence or infrequency among us of unnatural modes of indulgence in sexual intercourse, in which supposition he is, it is to be hoped, perhaps, perfectly correct; but experience has demonstrated to the reporter the fact that the majority of cases of extra-genital syphilitic chancre are the result of accident and not of unnatural practices; consequently in proportion to the extent of prevalence of syphilis among us, are we liable here or elsewhere to these lesions in anomalous localities; indeed Henry's cases prove this point. The true explanation in our opinion is that observers have frequently reported these cases in other countries and we have not. Besides there are more works written on syphilis abroad than with us. We purpose shortly presenting in the clinical department of the ARCHIVES the details of a quite large number of cases of this class, since they are of interest as statistics as well as clinically.

As KASZLINSKI's contribution (6) is simply his inaugural dissertation, it leaves hope that in future he may do better and more correct work. His present performance is evidently the offspring of limited experience and confused ideas. It is to be expected that when he has treated a larger number of cases, and has further pondered over his juvenile thesis, he will reconsider his rash statements as to the curability of syphilis by the excision of its initial lesion.

MASON (8) gives the details, which he has carefully collated from the chief English medical weeklies, of all the cases of extra-

genital syphilitic chancres which have been therein reported for the twenty years prior to 1874. His observations lead him to think that very little attention has been paid to these lesions, until within the last fifteen years. The chief value of Mason's paper consists in his statistical table, and in the condensation in one article of the histories of thirty-eight cases; some of which, however, were observed by himself. His conclusions differ from those of Sigmund of Vienna, as to the greater or less frequency of occurrence upon the two lips; thus while the latter says that such chancres are more frequently found upon the upper lip, Mason's tabulation of cases go to show that the lower lip is oftener involved than the upper. Again while Sigmund thinks that the greater proportion of such lesions occurs in males, Mason is of the opinion that they are more frequent in females. He also adds the interesting fact, that when occurring on the hand, such lesions are always found upon the male.

SITUATION.	Men.	Women.	Total.
Lips { Lower .....	4	7	11
Upper .....	2	4	6
Hand .....	7	..	7
Arm (vaccination) .....	1	..	1
Eyelid .....	1	1	2
Cheek .....	..	1	1
Tongue .....	1	..	1
Palate .....	1	1	2
Abdomen .....	1	..	1
Thigh .....	1	..	1
	19	14	33

He further reports five cases; one in which syphilitic contagion was transmitted by a cigar; a second by a lozenge; a third by catheterizing the eustachian tube; a fourth by sucking a wound; and fifth, a group of cases of French glass-blowers, who were contaminated from one man. The only point of distinction between the series of five cases and the previously reported one, is in the fact that the source of the infection was traced to secondary lesions. As Mason says, these cases are very interesting, particularly are those on the lip, in the question of diagnosis.

SCHWARTZ gives (9) a very satisfactory account of a case of syphilitic contagion by a uterine chancre. A woman, aged 20, applied at the Lourcine Hospital in March, 1874, to be examined, stating that she had not discovered any unusual symptom, but that she was fearful of trouble, as her lover had had, seven weeks

previously, an ulcer upon the penis which, at the Hôpital du Midi, had been called an "infecting chancre," and for which he was ordered to take pills and mercurial baths. The only external evidence of syphilis was the enlargement of two ganglia in the right groin. Examined with the speculum the neck of the uterus was found to be remarkably hard, and there was an ulceration around the orifice which was covered with a pultaceous diphtheroid film; its edges were beginning to cicatrize. In April, the lover, having accompanied the woman to the consultation, stated that in January he had had intercourse with another woman, and that soon after he had noticed an erosion. This had been treated, and at this time only an induration, at the end of glans near the meatus, was found. There was beside specific inguinal adenopathy, and the body was covered with a papular syphilide. In May, the woman presented syphilitic lesions. The interest in this case is in the confrontation, and in the localization of the two chancres. The woman was positive that she had not had intercourse with another man.

VENOT (10) reports two cases of ulceration upon the cephalic region, which he thinks were of chancroidal nature. The rarity of undoubted cases, as well as the significant question as to whether all auto-inoculable ulcers found in this region are to be regarded as chancroidal, call for the report in full of all such cases. The first is that of a prostitute, aged 19, who having had no antecedent venereal disease, had, a year previously, an abscess of the labium majus. She consulted Venot for an ulceration of the border of lower lip of twenty days' duration. It was nearly round, of a diameter of one and a half centimeters, with sharply cut, red edges, greyish base and secreted much sanguous pus. It presented no induration, and appeared like a chancroid. A single sub-maxillary ganglion was swollen and tender. She was cured in about a month by local treatment without any suppuration of the ganglion, and afterward did not give any evidence of syphilis.

The second case was that of a man who, after some impropriety, noticed a sinuous ulceration of the left labial commissure extending to the integument beyond. It commenced by a slight papule, which, becoming excoriated, was touched with spirits of camphor by which it was much inflamed. The patient, an intelligent man, somewhat read in medicine, went to Venot in great fear, saying that cephalic chancres were always of an infecting character. There was considerable suppuration but no induration, and a

ganglion in the parotid region was enlarged and tender. To appease the anxiety of the patient, auto-inoculation upon the right thigh was practiced with success. The resulting ulcer is said to have presented all the appearances of a soft chancre in about seven days. The mind of the patient was thereby much relieved. Venot states that his father submitted a case of soft cephalic chancre to Ricord many years ago. This statement seems singular, as the case of the elder Venot was pronounced by Ricord to be one of lupus, and not of chancroidal nature. The diagnosis of the latter is very clearly given in his work. (*Leçons sur de Chancre*, p. 16, Paris, 1860.)

## THE TREATMENT OF SYPHILIS.

1. **Beck, J. R.**—On the use of iodide of potassium in syphilis. *Philadelphia Med. Times*, March 13, 1875.
2. **Brush, E. N.**—A reply to the article by J. R. Beck, on the use of iodide of potassium in syphilis. *Philadelphia Med. Times*, April 24, 1875.
3. **Drysdale, C. R.**—On the antecedents and treatment of tertiary syphilis. *Med. Press and Circ.*, March 3 and 10, 1875.
4. **Hermann, J.**—On the nature of syphilitic affections, and upon the mercurial treatment. (*Sur la nature des affections syph. et sur le traitement mercuriel.*) *Gaz. des Hôpitaux*, Jan. 12, 1875.
5. **Jakubowitz, Franz.**—Parenchymatous injections, a new mode of treatment of syphilitic bubo. *Wiener Med. Presse*, Nos. 3 and 4, 1875.
6. **Lane, J. R.**—Address on the modern treatment of syphilis. *Brit. Med. Jour.*, December, 1874.
7. **Lawrence, G. W.**—Treatment of venereal warts. *Richmond and Louisville Med. Jour.*, July, 1874.
8. **Milton, J. L.**—On the treatment of secondary syphilis. *Edinb. Med. Jour.*, March, 1875.
9. **Paget, James.**—Combination of carbonate of ammonia with iodide of potassium in the cure of syphilis. *Brit. Med. Jour.*, January 10, 1874.
10. **Roberts, J. D. W.**—Oleate of mercury in syphilis. *Cincinnati Lancet and Observer*, May, 1875.
11. **Sturgis, F. R.**—On the use of mercury in the late stages of syphilis. *Am. Jour. Med. Sci.*, January, 1875.

12. **Stefanini, Domenico.**—Subcutaneous injection of calomel as a means of diagnosis in a doubtful case of syphilis. (*La iniezione sottocutanea di calomelano, etc.*) Giorna. Ital. delle mal. V. e del. pelle., April, 1874.

13. **Watson, P. H.**—On the uselessness of mercury in syphilis. London Med. Record, Dec., 1874.

14. **Wilders, J. S.**—The treatment of syphilis by moist mercurial fumigation. Brit. Med. Jour., January 23, 1875.

15. **Anonymous.**—Treatment of syphilis. Correspondence Med. Times and Gaz., No. 6, 1875.

BECK's paper (1) is a dogmatic assertion, unsupported by any facts or by careful reasoning, that mercury is harmful in the treatment of syphilis, and that iodide of potassium, in large doses, is beneficial and curative in all stages of the disease. There is an undertone of arrogance in the author's allusions to those who entertain views of the value of mercury, which is not only in bad taste, but also unbecoming in what should be a dignified scientific discussion. The author endeavors to disclaim and forestall criticism by stating that this paper is but the forerunner of another, in which he will give statistical evidence; but it certainly would have been more judicious—considering that he advances no reasons other than his own opinions—to have simply stated his views, without trying to demolish those of others who are acknowledged authorities. As for the "food for contemplation" which he offers to mercurialists in the two severe cases which he claims to have cured, the only surprise in the minds of the latter will be, that the author should wonder that he has done any thing unusual.

DRYSDALE's paper (3) is, in reality, a profession of faith. Having for years been an ardent advocate of anti-mercurial doctrines, he now—convinced chiefly by the writings of Fournier and Hutchinson—recants and secedes from that bigoted and illogical school. He states that he has used iodide of potassium in large doses, in secondary syphilis, with very good results. In future, however, he purposes, in the secondary stage, using protracted mercurial courses, in order to prevent, as claimed by Ricord and Fournier, tertiary lesions. He frankly admits that he has observed such lesions in patients whom he has treated by the non-mercurial plan. Coming from such a man the confession is very important, as most anti-mercurialists claim that these lesions are the results of mercury, and that they do not supervene except in

persons treated by that drug. According to his present belief and experience, mercury is only beneficial in the secondary stage, and he hints that it is not necessary, and is, perhaps, harmful in tertiary lesions. It is very probable that greater experience will demonstrate to him the necessity of a combination of mercury and iodide of potassium in late stages of syphilis.

HERMANN, (4) of Vienna, has long been known as a violent opponent to the use of mercury in syphilis, and his somewhat recently published work on the action of mercury (*Ueber die Wirkung des Quecksilbers auf den menschlichen Organismus*) is, perhaps, one of the most curious examples of wrongly interpreted facts, perverted statements and illogical deductions which has been written on syphilis for some years, and this assertion is strongly put when one thinks of the recent performance of his colleague Désprés, of Paris. It would seem either that Hermann has grown tired of a German audience, or the reverse, perhaps, has occurred, and that now he wishes to dogmatize in France. To this end he has sent a paper to the Academy of Science, which, for boldness of statement without the support of facts, is certainly a marvel. As the Parisians are almost to a man orthodox mercurialists, we can only explain the fact, that the dignity of reading was accorded to this paper by that learned body by the supposition that motives of curiosity actuated it. Hermann bases what he terms his doctrine upon, as he says, 20,000 cases of cure. His theses are as follows:

1. Syphilis should be considered as a local disease having consecutive forms, which bear intimate relations with the original lesion.
2. Mercury should be *banished* from its treatment.
3. Consider the so-called constitutional lesions as the effect of mercury.

He claims that in the general hospital of Vienna, in which mercury is used, one patient in eighty-nine is lost, whereas in his hospital they lose but one in 969. The study of the course of syphilis, uninfluenced by mercury, is claimed to throw light upon treatment, and to banish error. He in some cases uses electrolysis.

JAKUBOWITZ (5) recommends a peculiar mode of treatment for syphilitic glandular swelling. He claims also that its use may be extended to inflamed glandular tissue generally, as well as to cancer of the breast. It consists in parenchymatous injections

of a solution of iodide of potassium, fifteen grains, tincture of iodine, five drops, and one ounce of water. This is thrown by a hypodermic syringe into the substance of the glands. His procedure, as detailed in one case, is as follows: The needle of an ordinary hypodermic syringe, filled with the fluid, is thrust obliquely into the most prominent part of the swelling, a fourth part being injected. When resistance is felt it is withdrawn and injected in a different direction. In four such manœuvres the contents are exhausted. Several such injections may be required. No pain usually attends the introduction of the needle. A slight uneasiness is caused by the tension of the fluid, and after the injections the sensations are so slight that no detention from business is experienced. J. reports two cases. It would seem that this treatment may be beneficial in those not uncommon cases in which the glands are very much swollen.

LANE's paper (6) is the expression of his observation and study for a period of twenty-three years, and while it does not advance any new or striking facts, it is interesting as a contribution to our general knowledge, and important as a tribute to the value of mercury and the iodides. He reviews, in a very candid manner, the indications for the treatment of syphilis in all of its stages. He alludes to the facts of infection by syphilis a second time, which he considers an evidence that the disease is often cured, and from this and from the fact that syphilitics often beget healthy children, he concludes that the disease is not the life-long companion of its victim, but that it is radically curable. He favors the view that syphilis should be treated early; that mercury should be given when the diagnosis of a syphilitic chancre is clearly made. He thinks that this course tends to prevent further trouble, and he is convinced that by it he has prevented any further manifestation of syphilis than its initial lesion. While, however, he advises the use of mercury, he enjoins caution; and in phagedenic complications of chancres he thinks that it should be discontinued entirely. Again, in very mild forms of secondary syphilis, he seems disposed to rely upon the natural tendency of the lesions to disappear without administering the remedy. His practice is to use the drug in those persons who enjoy good health, and he proceeds very cautiously with it in those of the strumous diathesis. Indeed, in many of the cases he does not use mercury. He favors a rather protracted course similar to that advocated by Ricord; but he does not consider the supplementary

medication by iodide of potassium, recommended by the latter, as necessary. Of the form of the drug he is disposed to prefer blue pill mass, in doses of five grains daily at two portions, combined with the sixth of a grain of opium. Administration by the mouth, he thinks, is preferable to inunction, vapor bath and injection subcutaneously. In tertiary syphilis he places as full reliance upon the iodides as he does upon mercury in the earlier stages; but he also recognizes the necessity, in some intermediary conditions, of giving a combination treatment. He alludes to a point in the administration of the iodides, which he states is important. He thinks that much more benefit accrues to a treatment beginning with small doses, rather than by very large ones. He thinks it better to begin with, at first, three or four grains thrice daily, increasing by a grain every four days until a dose of fifteen to twenty grains is reached. He thinks that it is to be regretted that the decoction of sarsaparilla has fallen into disuse, as it is a valuable adjuvant and vehicle for the iodides. He is convinced that carbonate of ammonia intensifies the power of these salts. If the potassium salt is not well borne, he uses ammonium or sodium bases, which, although not quite so efficient, are less irritating. In some cases of intolerance of the iodides, he has descended as low as to half grain doses of iodide of sodium, and by thus accustoming the system to its action he has been able to reach doses of from twelve to fifteen grains. He speaks of a case in which he thus brought about tolerance of the sodium salt, but in which the potassium salt could not be given. While he accords so much value to the iodides in the tertiary stage, he thinks that they are harmful in the secondary period.

STURGIS (11) calls attention to the fact that iodide of potassium alone is often powerless against the later syphilitic lesions, or that it requires unnecessarily long periods of administration before benefit results. He thinks that mercury is too little used in these cases, and that the more successful treatment is that in which both mercury and iodide of potassium are given together. He details two cases in which, after a prolonged trial of the latter drug, little effect was produced, and in which marked improvement was observed when mercury was added. As to the iodide he thinks that the dose should be large, and that the mercury is best administered in the form of inunction applied to the soles of the feet, the stockings being worn day and night. He speaks highly, in favor, on account of the rapidity of its absorption and

of its greater cleanliness, of the oleate of mercury, with or without morphia. The solution used by S. contains 20 per cent of the mineral. He speaks deprecatingly of the bichloride of mercury. As to the length of time of administering the two drugs, Sturgis thinks that treatment should be used until the symptoms disappear, or until its discontinuance is rendered necessary by the condition of the patient. In our experience, caution must be exercised in the use of so strong a solution as the 20 per cent oleate of mercury.

STEFANINI (12) reports the case of a young girl who having severe ulceration of the throat and velum, and irido-cyclitis, which were unsuccessfully treated by the usual means, were rapidly cured by injection of half a grain of calomel, suspended in glycerine. Though no history of syphilis was obtained as existing either in the girl or her parents, the author thinks that the results of treatment warrant the diagnosis of that disease.

WATSON's (13) address before the Medico-Chirurgical Society of Edinburgh is similar in the utter want of well-established facts, and of carefully collated observations to the greater number of the productions of the so-called anti-mercurialists. Like all such, this paper is merely the statement of belief, without giving good and sufficient reasons. The generally admitted and time-worn fact, that syphilitic eruptions may disappear without the use of mercury, is in this, as in most of the articles of its class, the *pièce de resistance*, and its author seems to think that only observers of his faith have ever watched a case of syphilis in its whole course untreated. The well-known assertion that tertiary lesions are produced by mercury, again confronts us, but reasons and facts relating thereto are not given. The author, as do many of his brethren, admits the necessity of mercury in some cases, particularly in those of tertiary lesions, which he claims to have been originally caused by that agent. His preferences are to the hypodermic injection of the bicyanide of mercury. The criticism suitable to this as to most papers of its class is, that it is the offspring of violent prejudice, rather than of clear reasoning and of pains-taking observation; indeed we look in vain for a calm, logical treatment of this subject, based on extensive research.

WILDERS (14), as a pupil and friend of the late Mr. Parker, of mercurial vapor-bath fame, thinks that Lane's allusion to the method of treatment so strongly recommended by his master, is

slighting, and not in accordance with facts. Lane says, "inunction is, perhaps, on the whole, to be preferred for hospital patients; but it is troublesome and dirty, and therefore it is often undesirable to resort to it in private practice. The same objection applies to fumigation, with the addition that it is, as a rule, more debilitating, for the nightly vapor bath has a decidedly depressing influence." Wilders coincides with Lane as regards inunctions, but as to moist fumigation he says: "I affirm with the utmost confidence that the treatment of syphilis by moist fumigation is neither troublesome or dirty, nor has it a decidedly depressing influence on the patient, but on the contrary, that it is a cleanly, rapid and most manageable method, and the most powerful therapeutic agent in the removal of disease, and the least hurtful to the constitution of the patient." Speaking further on of the reports in Parker's book of ninety-one cases, thus treated, he says: "I can most fearlessly affirm that they are a trustworthy record of the marvelous efficacy of this treatment, which was always open to the scrutiny of the profession." He concludes by giving the history of a bad case of syphilis which being uninfluenced by other methods of treatment was happily cured by the means he advocates.

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## INFANTILE AND CONGENITAL SYPHILIS.

FRED. R. STURGIS, M. D.

1. **Atkinson.**—Etiology of congenital syphilis histologically considered, N. Y. Medical Journal, January, 1875.

2. **Birsch, Hirschfield.**—Changes of the mesenteric glands in hereditary syphilis. (*Beiträge zur path. Anat. d. heredit. Syph. Neugeborner mit bes. Berücksichtigung einer Veränder. d. Bauchspeicheldrüse.*) Arch. d. Heilkunde, xvi 2, p. 166.

3. **Caspary, J.**—On the duration of latency in hereditary syphilis. (*Ueber die Dauer der Latenz bei hereditärer Syphilis.*) Berliner Klinische Wochenschrift, March 29, 1875.

4. **Cormack, J. Rose.**—Congenital syphilis. Med. Times and Gazette, Feb. 27, 1875.

5. **Hutchinson, J.**—Case of deafness in connection with hereditary syphilis. Med. Times and Gaz., January 16, 1875.

6. **Jackson, Hughlings.** — Nervous symptoms in congenital syphilis. *Journal of Mental Science*, January, 1875.

7. **Lashkewitz.** — Syphilis hereditaria tarda. *Vierteljahrsschrift für Derm. u. Syph.*, 1874, 1 Jahrg., 2 and 3 Heft.

8. **Porter.** — Cases of congenital bone syphilis in children. *Am. Jour. of Obstetrics*, February, 1875

ATKINSON, (1) in a paper on the etiology of congenital syphilis, arrives at the following conclusions:

1st. A syphilitic mother may primarily infect an ovum, which may subsequently become impregnated.

2d. She may, the ovum escaping subsequently, infect the embryo through the bioplastic elements of her own blood during the process of nutrition.

3d. A father may also, through the sperm cell, infect the germ cell impregnated by it, the result being a syphilitic embryo.

CASPARY, (3) after reviewing the variety of opinions which obtain among authorities as to the length of time during which hereditary syphilis remains latent in children, combats the notion that it does not occur after the third month of extra uterine life. He quotes two cases from his own practice, in one of which the syphilitic symptoms appeared three and a half months, in the other more than four and a half months after birth. In the case of twins he draws attention to the fact that, in one, the symptoms are often developed at once, while, in the other, months may elapse before they appear. He does not believe, as do some authors, that one of the twins may and does escape. Sooner or later, he thinks, the symptoms of the disease will make their appearance.

JACKSON, (6) in his paper, draws attention to the fact that, although congenital syphilis does undoubtedly give rise to affections of the nervous system, still, where the diagnosis is not verified by an autopsy, it is impossible for the physician to assert absolutely that the syphilis, in itself, was the cause of the train of nervous symptoms.

LASHKEWITZ (7) gives two cases of amyloid degeneration in two adults; one, a woman, at 22, the other, in a boy 14 years of age, due, in his opinion, to hereditary syphilis. There is no evidence, from the histories, of early syphilis in either of the cases, and he bases his opinion upon the amyloid degeneration of the viscera found upon post-mortem.

## SYPHILITIC DISEASE OF THE EYE AND EAR.

CHARLES S. BULL, M. D.

1. **Knapp, H.** — Neuro-retinitis resulting from a gummy tumor of the dura mater. *Arch. of Ophthal. and Otology*, IV, 2.
2. **Lawson.** — Intra-uterine syphilitic iritis. *Med. Times and Gaz.*, April 3, 1875.
3. **Rankin, F. H.** — Syphilitic atrophy of both optic nerves. *N. Y. Med. Record*, March 13, 1875.
4. **Taylor, R. W.** — Syphilitic lesion of the lachrymal caruncles. *Am. Jour. Med. Sciences*, April, 1875.

KNAPP (1) reports a case in which the retina showed the ordinary picture of neuro-retinitis passing into atrophy of the optic nerve. The patient had contracted the initial lesion of syphilis eleven years before, which was followed by the ordinary constitutional symptoms. There were periosteal nodes on the bones of the skull, constant headache, epileptiform convulsions, and exophthalmus of both eyes with impaired vision. At the autopsy, a large gummy tumor was found, growing from the dura mater, at the anterior portion of the left anterior cerebral lobe, and the surrounding brain substance was softened. The important point in the case was the fact that though the growth was situated remote from the cavernous sinuses, it still had set up a double neuro-retinitis.

LAWSON (2) reports a case of intra-uterine syphilitic iritis. The case was a girl, seven months old, in whom the left eye presented the appearance of an old attack of iritis. The pupil was irregularly contracted, there were complete posterior synechiæ, and a deposit of lymph on the centre of the anterior capsule. The child had always been delicate, but the eye had never been inflamed since birth. There was an eruption upon the nates and vulva.

A case of syphilitic atrophy of both optic nerves is reported by RANKIN (3). The patient was a man, 27 years old, who had contracted the primary lesion ten years before, which was followed by the usual constitutional symptoms. Later he suffered from severe head symptoms, agonizing left hemicrania, high fever, nausea, wandering delirium, photophobia and impaired vision. He recovered from this attack, and believes his vision was normal.

Five weeks before the doctor saw him, vision began again to fail in the left eye. On examination the pupils were normal, L. E. V., perception of light, R. E. V. =  $\frac{16}{200}$ . The field of vision was limited on the superior nasal and inferior sides. There was marked atrophic discoloration of both optic nerves, the disks being of a blueish-white, with irregular outline. The treatment was by mercurial inunction, ol. morrhuae, iron and quinine, and hypodermic injections of strychnia daily. The mercury was discontinued on 10th day, and potass. iod. ordered. The strychnia was continued, and increased up to gr.  $\frac{1}{6}$ . After six months' treatment, vision was restored to the normal standard, and the visual field was also normal.

In a paper upon Syphilitic Affections of the Lachrymal Apparatus. Dr. Taylor (4) recites the histories of two cases of a gummy infiltration of the caruncles, an extremely rare affection, and one previously unrecorded. The cases prove that the caruncles may be primarily involved by syphilis without the implication of other parts. The patients were both men, and in both the caruncles enlarged in a subacute, painless manner. In the first case the enlargement appeared three years after the contraction of the initial lesion, and coincidentally with a general rupial eruption over the body and extremities. The caruncles were enlarged to four times their natural size, and were pyramidal. There was some difficulty in closing the lids. The caruncles were hard and shining, but there was no ulceration or discharge. They were removed by another surgeon who mistook them for cancerous degeneration of the caruncles, and there was considerable resulting deformity.

The second case could give no distinct history of the primary lesion, but had suffered from many of the constitutional symptoms. He had a general cutaneous eruption upon the body early in 1868, and in the latter part of 1869 he noticed a swelling at the inner angle of each eye. Dr. Taylor saw him in January, 1870, and found two tumors of similar appearance to those in the first case, though somewhat larger. There was no ulceration and no discharge. The patient was placed upon combined treatment, and after 10 months the caruncles were reduced to their normal size. The process of absorption, however, went on and resulted in atrophy of the little bodies.

The two cases are reported with great care and minuteness, and are a valuable contribution to the pathology of the caruncles.

5. **Bull, C. S.** — Two cases of interesting Syphilitic Lesion of the Eye. Trans. of the Am. Ophthalmological Society for 1874.

The *first* case was an external growth or gumma, involving the subconjunctival fascia and sclera, and connected with a similar gumma of the ciliary body. The primary lesion had been contracted about ten years before, and had been followed by an obstinate affection of the skin, faecal ulcers and alopecia, which lasted for more than two years. About three years after the appearance of the initial lesion, she had an attack of irido-choroiditis in the left eye, which left her with only a small amount of vision. Seven years later a second attack came on in the same eye, and vision sank to perception of light. The patient also noticed a swelling over the ciliary region between the superior and external recti muscles, which was rounded at the periphery, about 2''' in height, and extended back about half an inch in a straight course. The overlying conjunctival vessels were immensely engorged and tortuous, and the eye was very painful. After dilating the pupil, the vitreous was found filled with floating masses. In the upper and outer part was a stationary dark-brown mass about the size of a large pea, which occupied a position corresponding exactly to that of the scleral growth outside, and the two were probably connected together. It is rather remarkable that the iris was not involved in the process, since gummata are so commonly met with here. The right eye had always remained unaffected.

The *second* was a case of *choroiditis disseminata* of syphilitic origin. The initial lesion had been contracted thirteen years before, and had been followed by a cutaneous eruption, ulcerated fauces, alopecia, and most obstinate and painful periostitis of the frontal bone, clavicle and tibia. One year after the occurrence of the chancre, the *right* eye became violently inflamed, and the process was not arrested till nearly six months had elapsed, leaving the vision almost lost. The eye has had several repetitions of the same trouble. Three years ago he had an attack of cerebral hemorrhage, was unconscious for seven days, and was *paraplegic*. About six months ago the vision of the *left* eye began to fail. In the right eye  $V. = \frac{2}{100}$ , in the left eye  $V. = \frac{2}{70}$ . The ophthalmoscope showed marked choroiditis disseminata in both eyes, with atrophic degeneration of the optic disks. All over the fundus, though most markedly in the region of the equator, were scattered irregular masses of pigment, as is usual in this form of choroiditis. But in the neighborhood of the posterior pole of the eye, around the macula and optic disk, the pigmentary deposit was very abundant, and arranged in a peculiar manner. The spots of pigment were nearly all of the same shape and size, hexagonal, and arranged like the hexagonal pigment cells of the external surface of the retina, and presented the same appearance as the microscopic drawings of these cells which we see in the anatomical descriptions of the minute structure of the eye. Most of the deposits were posterior to the retinal vessel, though sometimes the vessels were covered by them.

## Reviews and Book Notices.

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### *Recent German Works upon Syphilis.\**

IT is a matter of congratulation that the subject of syphilis has received so thorough and able a treatment in this classical Encyclopædia of Medicine which Ziemssen is furnishing, Bäumler, in 309 pages, many of them printed in fine type, giving the fullest and, in many respects, the most exact and valuable account of syphilis accessible to the English reader. His dualistic views as to the relations of what is commonly known as the chancroid and the initial lesion of syphilis may be best expressed in the following quotation : "We accept only one syphilitic poison, but in another sense from that given to it in the doctrine of unity. We do not regard the contagious principle of chancre (chancroid) as identical with this poison. It is a pathological agent by itself, but a far less constant and uniform one than the poison of syphilis, since we have seen that it may be generated *de novo* under the co-operation of certain influences, and quite independently of syphilis."

The lesions of the skin and mucous membranes are well given ; indeed the whole subject of syphilis is presented in a thorough and painstaking manner, which must long make this a valuable book of reference and study. The bibliography, especially to more recent current literature, is surprisingly complete.

Zeissl's large work of almost 700 pages, 426 of which are devoted to syphilis, together with the separate atlas in octavo, containing 28 lithographic plates (most of them colored), with descriptive text, forms a very complete exposition of the diseases of venereal origin. The appearance of a third edition of a book is often taken as evidence of its worth, and in many respects that before us will bear this out, for on some points it is more full than any other. One hundred pages are devoted to the cutaneous developments of syphilis, and nearly 40 more to those on the mucous surfaces. The

\*Syphilis. Christian Bäumler. Ziemssen : Cyclopædia of the Practice of Medicine, Vol. III., New York, 1875.

Text-book of syphilis and the related local venereal diseases (Lehrbuch der Syphilis und der mit dieser verwandten ortlichen venерischen Krankheiten.) H. Zeissl. Third enlarged edition, with wood cuts and 28 chromo-lithographic plates, by Julius Heitzman.

Syphilis of the skin and adjoining mucous membranes. (Syphilis der Haut und der angrenzenden Schleimhäute.) Moriz Kaposi, 1873, 1874 and 1875, with chromo-lithographs by Carl Heitzman.

descriptions are good and the differential diagnosis well drawn. With regard, however, to the accompanying atlas of plates as much cannot be said, for they fall far short of what we had hoped to find. We do not regard them true to nature, though it were difficult to state exactly where the defect lies; but there is a coarseness of delineation and in general an exaggerated coloration; the purple flush is often too deep and the idea of elevation of the eruption is often lost entirely. Some of the plates are more natural, as those numbered 2, 4, 13, 15, 20 and 21, but the general appearance of the others is far from being satisfactory.

Quite other are the delicate and life-like plates in Kaposi's great atlas, now complete in three sections, with a total of 76 large quarto chromo-lithographs and several wood cuts. In this the reading matter is quite secondary to the illustrations, although Kaposi's clear descriptions add much to the value of the work. But as he is a believer in the identity of the poison of the chancre and chancreoid, or as Bäumler and others say the (soft) chancre and the initial lesion of syphilis, errors may be caused in readers' minds who are not fully acquainted with the proper dualistic theory, and confusion result. Zeissl is a strong supporter of the non-identity of these poisons.

*Syphilitic Lesions of the Osseous System in Infants and Young Children,*  
by R. W. TAYLOR, M. D., Surgeon to the New York Dispensary,  
Department of Venereal and Skin Diseases; Physician to Charity  
Hospital, New York.

Dr. Taylor, adopting the German manner, has divided his book into sections and not into chapters, which latter, perhaps, would be more convenient for the reader in cases of reference than it now is. These sections number thirty, exclusive of an appendix. The first is an introductory one, sketching the position of our knowledge of these lesions prior to Wagner's paper in 1870; then follow the histories of the author's personal cases, in all twelve in number, and which are carefully and critically reported, succeeded by a résumé of the cases of other observers. The clinical description, together with that of the sequelæ of these lesions of the bones, occupy the sections from iv to xviii inclusive, the remainder of the book being chiefly occupied with a consideration of the period of invasion of these lesions, the stage of syphilis in the mothers in whose infants osseous lesions are observed, the pathological anatomy of these lesions, the question of the relation between Rachitis and Syphilis with the differential diagnosis, the treatment, etc.

It seems invidious, in a work which shows signs of so much careful study, to pick out certain portions as better than others, but if

such be allowable, in our opinion, the latter portion of the work is better than the earlier. Particularly praiseworthy is the section devoted to the question of difference between Rachitis and Syphilis.

It has been for a long time customary, particularly among the older members of the profession, to regard syphilis as a fruitful source of rickets and scrofula, forgetting entirely the fact that although rickets may occur in a syphilitic subject, as in a phthisical one, it is due rather to accidental causes than as a direct effect. One point which has been most productive of error in this respect has been mistaken diagnosis. It is only within a few years that special attention has been called to the lesions of the bones in congenital syphilis, and probably many cases which now would be ascribed to syphilis were formerly laid to the door of scrofula or rickets. The way in which the question has been heretofore formulated has been a bad one, and as Dr. Taylor himself shows, should stand, "Is rachitis one of the usual conditions or lesions produced by syphilis," rather than "Can syphilis produce rickets?" We commend for this and following sections careful perusal.

Unfortunately space forbids our doing more than giving a very cursory notice (review it can scarcely be called) of the book in question, but before closing this account let us turn for a few minutes to the section devoted to the treatment. Dr. Taylor inclines to the use of the so-called mixed method, *i. e.*, mercury and iodide of potassium in combination, in the shape of the bichloride or biniodide and the iodide. Hypodermic injection he very properly abandons, giving good and sufficient reason therefor. His strictures upon the use of inunctions with mercurial ointment, we confess, surprised us, for we have found them to work admirably where properly used. Dr. Taylor says:

"Much has been said of the value of mercurial inunctions as a speedy and certain way of inducing the effects of the mineral. They are, in many instances, of infinite value in adult acquired syphilis; but in that of infants are apt to produce severe cutaneous inflammation, and sometimes grave systemic disturbance, such as great enfeeblement, impoverishment of the blood, with cachexiæ. For these reasons, and also because in these cases their use is to be extended over such a long period, and that it is almost impossible to get the attendants to use them intelligently and regularly, I am not disposed to advise them, notwithstanding their great potency as used in the adult."

It gives us sincere and genuine pleasure to welcome the book, doubly so as coming from this side of the water, and to commend it to the attention of those interested in veneral diseases as the only work of the kind, so far as we know, in any language.

F. R. S.

*The Influence of Alcoholism in the Development of Certain Diseases of the Skin (Essai sur l'influence de l'alcoolism, etc.),* by A. RENAULT. Thèse de Paris, 1874.

This thesis demands more than a passing notice, on account of the importance of the subject of which it treats, which has hitherto been ignored too much in the study of skin diseases. Renault shows that the physiological action of alcohol is such as to predispose more or less to cutaneous diseases. 1. Because it is eliminated by the skin. 2. Because a small dose produces general nervous excitation and a large dose depression. 3. Because of its diminishing the amount of carbonic acid exhaled and lowering the temperature; and, 4. Because of its tendency to produce fatty change in the tissues. Assuming somewhat too decidedly that rosaceous acne is caused by alcoholism, he claims this for pellagra and also something called Ulcères du Gin, to which merely allusion is made. He gives a case of hydroa where bullæ had developed twenty times within seven years, almost always succeeding alcoholic abuse.

The most important part of the essay is that devoted to the influence of alcohol upon the tertiary syphilides, where he endeavors to show by cases that, 1. Alcoholism is one of the most powerful causes of the late cutaneous manifestations of syphilis; 2. That these develop in spite of an antecedent mercurial course; and, 3. That the syphilides in drunkards are mainly ulcerating. Another valuable portion is that relating to psoriasis, where he thinks that alcohol causes a greater development of the disease and more active phenomena of itching, etc. This is also supported by series of cases. Unfortunately he makes no distinction between the fermented and distilled liquors, his patients taking from 4 to 8½ pints of wine a day, often with brandy, absinthe, etc. He thinks also that it may be shown that varicose eczema is more common in those addicted to alcohol, and that alcoholic excess predisposes to fresh attacks of eczema. Also, that excess of drink will induce greater itching in this disease. The subject is a very interesting one and deserves much greater study and clinical research, as it may be one of vital import to patients. The thesis is clearly and pleasantly written and well repays study. We trust that this will be but the beginning of M. Renault's studies in Dermatology.

*The Relations of Erythema Papulatum to Rheumatism (De l'erythème papuleux, dans ses rapports avec le rhumatisme),* by CAMILLE COULAUD, Paris, 1875.

In this brochure, the author attempts to prove that erythema papulatum is identical in nature with erythema nodosum, and that it is a cutaneous localization of the rheumatic diathesis. This view

## EDITORIAL.

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With the completion of the first volume of the ARCHIVES OF DERMATOLOGY, the Editor would again acknowledge the kind encouragement and support he has received from all sides. The press of material has been beyond all expectation, and each issue has found the pages of the Archives more than full. This was partly due to the desire to present a complete digest of all the literature in these departments, for the year 1874, and having brought this and the Review department up to date, it is hoped that there will, in future, be more room for original articles and clinical reports.

In the next issue there will be begun a series of practical articles, intended mainly for the general practitioner, illustrative of the diagnosis and most recent and best treatment of the more commonly met with affections of the skin. In order to insure their practical character, they will be in the form of *Clinical Conversations*, and will be, in the main, a report of the cases treated at the Demilt Dispensary, and the remarks made to private classes there, embracing also cases from private practice, when desirable.

The large amount of space in the present issue devoted to the department of Digest of General Syphilis needs no apology, as the subjects there presented are of vital import to every practitioner. Space has been economized by printing the Index in close double column, and it is hoped that its completeness will give satisfaction. The Editor acknowledges his great indebtedness to Dr. Robert Campbell in its preparation.

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